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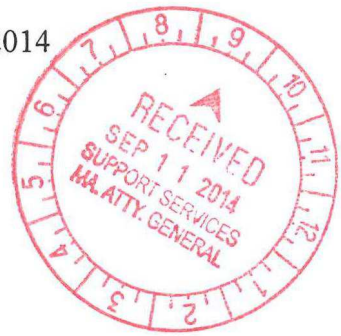
September 11, 2014



Via Hand Delivery
Antitrust Division
Office of the Attorney General
Commonwealth of Massachusetts
One Ashburton Place
18th Floor
Boston, MA 02108

Re: ***Commonwealth of Massachusetts v. Partners Healthcare System, Inc., et al,***
Civil Action No. 14-2033-BLS2

Dear Sir or Madam,

Pursuant to the July 17, 2014 Order in the above-referenced civil action, on behalf of Atrius Health, Inc., Beth Israel Deaconess Medical Center, Inc., Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc., Lahey Health System, Inc., Mount Auburn Hospital, New England Baptist Hospital, and Tufts Medical Center, Inc., enclosed for submission are two documents to be forwarded to Judge Janet L Sanders.

The first is a letter to Judge Sanders (numbering four pages). The second document is a detailed set of Comments on the proposed Final Judgment by Consent between Partners Healthcare System, Inc. and your office (numbering 82 pages total). Please provide both documents in full for Judge Sanders' attention and that you confirm the filing with undersigned counsel. Please contact us with questions.

Sincerely,

Andrea Agathoklis Murino

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September 11, 2014

The Honorable Janet L. Sanders
Superior Court Justice
Suffolk Superior Court
Commonwealth of Massachusetts
Three Pemberton Square
Boston, MA 02108

Via Hand Delivery Care Of:
Antitrust Division
Office of the Attorney General
Commonwealth of Massachusetts
One Ashburton Place
18th Floor
Boston, MA 02108

Re: ***Commonwealth of Massachusetts v. Partners Healthcare System, Inc., et al,***
Civil Action No. 14-2033-BLS2

Dear Judge Sanders,

On behalf of Atrius Health, Inc., Beth Israel Deaconess Medical Center, Inc., Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc., Lahey Health System, Inc., Mount Auburn Hospital, New England Baptist Hospital, and Tufts Medical Center, Inc., we write today to provide our Comments on the proposed Final Judgment by Consent ("Proposed Consent") between Partners Healthcare System, Inc. ("Partners") and the Attorney General of the Commonwealth of Massachusetts ("Attorney General"). As we explained at the initial hearing on this matter, the Proposed Consent will result in substantial and continuing increases to the already unsustainably high cost of health care services in the Commonwealth.

As context for our Comments, we note that the origin of this problem is the 1994 merger of former rivals Massachusetts General Hospital and Brigham and Women's Hospital, which created Partners. Since that time, Partners has acquired six additional hospitals and grown its network to include more than 7,000 physicians. As a result of this expansion, health care services in Massachusetts have become increasingly concentrated in Partners' high-cost facilities.[1] Partners' hospitals generally receive the highest prices in their service areas, and

[1] For example, if the Proposed Consent is approved, the Massachusetts Health Policy Commission ("HPC") estimates that Partners' share of commercial hospital discharges would grow from 24 percent in 2009 to 32 percent in 2014, a greater share than the combined shares of the next four highest-volume systems. *See* COMMONWEALTH

Partners' physician groups receive higher prices than nearly all physician groups in Massachusetts.[2] Moreover, the Attorney General has demonstrated that such prices are not the result of Partners' patients being sicker than patients of other providers or the quality of Partners' services being better than the quality of other providers' services.[3] Taken together, Partners' dominant market position acquired over the past 20 years has allowed it to increase its health care prices to anti-competitive levels and increase the concentration of health care provided in its higher-cost facilities resulting in unsustainable levels of health care spending in Massachusetts. Per capita health care spending in Massachusetts is now the highest of any state in the nation.[4] Meanwhile, Partners has used its market power to accumulate total net assets that are more than double the combined assets of the next five largest health care systems in Massachusetts and to obtain nearly one-third of all dollars spent on health care services in the Commonwealth.[5]

The Partners-driven increases in health care costs are directly passed on to Massachusetts consumers and employers in the form of higher health insurance premiums. Employers have responded to these increases by requiring their employees to pay for larger portions of those premiums, as well as by offering their employees plans with lower premiums but higher co-pays and deductibles, which require them to pay more out-of-pocket costs for the health care services they need. Increasing health costs also depress wages because dollars that employers spend on paying health insurance premiums are dollars that cannot go into their employees' paychecks. This increased spending has also diverted taxpayer money to Partners that could have helped meet urgent housing, education, and transportation needs in the Commonwealth. Since 2001, health care spending in the Massachusetts state budget increased 37 percent while non-health care spending decreased by 17 percent.[6]

OF MASSACHUSETTS, HEALTH POLICY COMMISSION, JULY 2014 SUPPLEMENT TO 2013 COST TRENDS REPORT, at 27 (July 2014), *available at* http://www.mass.gov/anf/docs/hpc/07012014-cost-trends-report.pdf.

[2] *See* COMMONWEALTH OF MASSACHUSETTS, HEALTH POLICY COMMISSION, REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITIONS OF SOUTH SHORE HOSPITAL (HPC-CMIR-2013-1) AND HARBOR MEDICAL ASSOCIATES (HPC-CMIR-2013-2): FINAL REPORT, at 14–17 (February 19, 2014), *available at* http://www.mass.gov/anf/docs/hpc/20140219-final-cmir-report-phs-ssh-hmc.pdf; COMMONWEALTH OF MASSACHUSETTS, HEALTH POLICY COMMISSION, REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITIONS OF HALLMARK HEALTH CORPORATION (HPC-CMIR-2013-4): FINAL REPORT, at 23–25 (Sept. 3, 2014), [hereinafter HPC PARTNERS-HALLMARK FINAL REPORT].

[3] *See, e.g.*, COMMONWEALTH OF MASSACHUSETTS, OFFICE OF THE ATTORNEY GENERAL, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS, at 34 (April 24, 2013), *available at* http://www.mass.gov/ago/docs/healthcare/2013-hcctd.pdf [hereinafter 2013 COST DRIVERS REPORT] (noting discrepancies in TME across the Commonwealth, and noting the Partners maintains the highest TME in four out of the five regions of the Commonwealth measured).

[4] *See* 2013 COST DRIVERS REPORT, *supra* note 3, at 8–12.

[5] *See* HPC PARTNERS-HALLMARK FINAL REPORT, *supra* note 2, at 18–19, 22–23.

[6] *See* Evan Horowitz, *As Health Care Costs Grow, Everything Else Shrinks*, BOSTON GLOBE, July 11, 2014, *available at* http://www.bostonglobe.com/news/politics/2014/07/11/health-care-costs-grow-everything-else-shrinks/eHg0m4B4LTIWkwiqp6DiVN/story.html.

For the following reasons, and as described in much greater detail in our Comments, the Proposed Consent would not impose meaningful limits on Partners' market power, which would grow because of the hospital acquisitions and physician network expansion that the Proposed Consent would permit:

- The **unit price growth cap** can be manipulated in several ways, and would be in force for only 6.5 years, during which time Partners would maintain, and likely improve, its market-power-derived price advantage over other providers, and after which time Partners could use its increased market power to raise its prices with impunity.

- The **component contracting** remedy places no meaningful restrictions on Partners' ability to continue to use its bargaining leverage to extract higher prices and other favorable contract terms from payers. It is a disfavored remedy with no record of success in Massachusetts or any other market.

- The **community physician growth** restriction is, in fact, an ambitious Partners' community physician network *growth plan*, allowing Partners to grow its existing community physician network by 33 percent over the next five years, which would then be larger than any of the current total (i.e., community and Boston-based) physician networks of its principal competitors, not taking into account the thousands of academic specialists in Partners' network. Moreover, because these networks would shrink as Partners' network grows, this size differential would grow greater over the next five years.

- In summary, the Proposed Consent offers remedies that are a patchwork of unproven behavioral constraints disfavored by other federal and state antitrust enforcers which would impose a tremendous burden on the Compliance Monitor and the Court to interpret and enforce during their five-to-ten year terms, and authorizes a substantial increase in the number of hospitals and physicians under Partners' control, which would further enhance its already dominant market position.

Perhaps most tellingly, since Massachusetts' own Health Policy Commission, an independent state agency that develops policy to reduce health care cost growth and improve the quality of patient care, released its Final Report on Partners' proposed Hallmark acquisition, the Attorney General and Partners have begun re-negotiating the terms of the Proposed Consent.[7] These reopened negotiations are a clear acknowledgment that the Proposed Consent's proffered remedies, as originally submitted to this Court, are inadequate. To the extent these re-negotiations result in changes to the Proposed Consent, we respectfully request additional time to review the changes and the ability to comment.

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[7] State House News Service, *Massachusetts Policy Commission Calls for Changes in Proposed Settlement between Partners HealthCare and Attorney General's Office*, Mass Live (Sept. 3, 2014, 8:20 PM), *available at* http://www.masslive.com/business-news/index.ssf/2014/09/massachusetts_health_policy_commission_c.html (quoting Brad Puffer, spokesman for the Attorney General, as stating that "[t]hose negotiations begin today").

***

We urge the Court to consider our Comments, including the many questions posed in our submission, and to reject the Proposed Consent. This Proposed Consent does nothing more than further entrench Partners' monopolistic hold on the Commonwealth's healthcare industry. If approved, citizens of the Commonwealth will be left paying far more for healthcare than they should in an otherwise competitive landscape. We believe this result is decidedly against the public interest and it is incumbent on this Court to prevent such an outcome.

Sincerely,

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Enclosure

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

SUPERIOR COURT DEPARTMENT
OF THE TRIAL COURT
CIVIL ACTION NO. 14-2033 BLS-2

COMMONWEALTH OF MASSACHUSETTS,

Plaintiff,

v.

PARTNERS HEALTHCARE SYSTEM, INC., SOUTH SHORE HEALTH AND EDUCATIONAL CORP., and HALLMARK HEALTH CORP.,

Defendants.

Comments of Atrius Health, Inc., Beth Israel Deaconess Medical Center, Inc., Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc., Lahey Health System, Inc., Mount Auburn Hospital, New England Baptist Hospital, and Tufts Medical Center, Inc.

to The Honorable Janet L. Sanders

via the Office of the Attorney General

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I. INTRODUCTION AND OVERVIEW[1]

Everyone knows, and there is no real dispute, that Partners Healthcare System, Inc. ("Partners") has substantial market power, and that it has wielded that power for two decades to increase health care costs in the Commonwealth to unsustainable levels. Partners already receives 28 percent of commercial health care payments in Massachusetts, more than three times the size of the next largest system in Massachusetts, Caregroup Health System, which receives nine percent.[2] Its market power has led to higher costs for health care services, which in turn has led to higher health insurance premiums, as well as higher co-pays and deductibles for consumers as employers continue to shift costs to their employees. And these increases in health care spending have continually diverted precious resources that could have been spent on urgent housing, education, and infrastructure needs without providing any additional commensurate benefit to citizens within the Commonwealth[3]—as the *Boston Globe* has noted, since 2001, health care spending in the Massachusetts state budget increased 37 percent while non-health care spending decreased by just 17 percent.[4] In considering any potential expansion of Partners, the question, therefore, is not *whether* Partners has market power; it is what to do about it.

Together, the Office of the Attorney General ("Attorney General") and Partners now propose remedies that impose short-term and ineffective price and contracting restrictions while allowing Partners to increase its market power through acquisitions of rivals and to maintain that

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[1] Capitalized terms not otherwise defined herein have the meaning assigned to them in the Proposed Consent.
[2] This percentage reflects calendar year 2011 but was made public in September 2014. *See* CTR. FOR HEALTH INFO. & ANALYSIS, ANNUAL REPORT ON THE PERFORMANCE OF THE MASSACHUSETTS HEALTH CARE MARKET, at 6 (September 2014) [hereinafter CHIA 2014 REPORT].
[3] The Attorney General has concluded Partners' prices are not justified by the quality of its health care services or the health status of its patients. COMMONWEALTH OF MASSACHUSETTS, OFFICE OF THE ATTORNEY GENERAL, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS, at 19 (April 24, 2013), *available at* http://www.mass.gov/ago/docs/healthcare/2013-hcctd.pdf [hereinafter 2013 COST DRIVERS REPORT].
[4] See Evan Horowitz, *As Health Care Costs Grow, Everything Else Shrinks*, BOSTON GLOBE, July 11, 2014, *available at* http://www.bostonglobe.com/news/politics/2014/07/11/health-care-costs-grow-everything-else-shrinks/eHg0m4B4LTIWkwiqp6DiVN/story.html.

increased power for the indefinite future. The so-called remedies allow Partners to absorb three (possibly four) hospitals, as well as hundreds of additional physicians, eliminating permanently the competition those providers had provided.[5] Because the Attorney General's and Partners' proposed remedies are so fundamentally contrary to public policy, this Court should reject them.

We are a group of Massachusetts non-profit hospitals and large physician groups, including Atrius Health, Inc., Beth Israel Deaconess Medical Center, Inc., Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc., Lahey Health System, Inc., Mount Auburn Hospital, New England Baptist Hospital, and Tufts Medical Center, Inc., who are intimately familiar with the provision and financing of health care services in the Commonwealth. We believe our industry know-how is highly relevant to this Court's assessment of the proposed remedies because we understand the day-to-day reality of providing and paying for health care services in the Commonwealth in ways that the Attorney General, by virtue of her expansive jurisdiction across all industries and matters, simply cannot. Accordingly, we have come together to offer this Court our best understanding of the many significant ways in which the proposed Final Judgment by Consent ("Proposed Consent") would do nothing but further enhance Partners' dominance at the expense of consumers throughout the Commonwealth. While cynics may say that we are simply disgruntled competitors, we would respond by saying that we are both competitors and providers seeking a more level playing field to be able to compete more effectively to reduce health care costs for the benefit of consumers within the Commonwealth. We welcome competition from Partners, but it must be fair competition.

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[5] Such providers include South Shore Hospital and affiliates, Harbor Medical Group, Hallmark Health Corporation and affiliates, and the 350 to 390 physicians over and above those in the South Shore Physician Hospital Organization/Harbor, plus potentially Emerson Hospital.

The Court, however, need not rely solely on our submission to draw these conclusions. Established by special legislation to examine health care transactions, Massachusetts' own Health Policy Commission ("HPC") reviewed the proposed acquisitions of South Shore Health and Educational Corporation and its affiliated entities ("South Shore Entities"), and of Hallmark Health Corporation and its affiliated entities ("Hallmark Entities"), and concluded the acquisitions are likely to lead to significant price increases and harm to consumers across the Commonwealth.[6] The HPC is a public body designed to assess and assure the competitiveness of healthcare in Massachusetts. Its expertise is, simply, unparalleled. These very experts have spoken clearly and emphatically in condemning both transactions, as well as the purported remedies the Attorney General and Partners now seek to use.[7] Their unbiased findings demonstrate that the Proposed Consent and any further expansion of Partners' network is fundamentally bad for the Commonwealth. Nevertheless, the Proposed Consent would allow Partners to proceed with the acquisitions of the South Shore Entities and the Hallmark Entities[8] on the heels of its recent acquisition of Cooley Dickinson Hospital.

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[6] *See* COMMONWEALTH OF MASSACHUSETTS, HEALTH POLICY COMMISSION, REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITIONS OF SOUTH SHORE HOSPITAL (HPC-CMIR-2013-1) AND HARBOR MEDICAL ASSOCIATES (HPC-CMIR-2013-2): FINAL REPORT (Feb. 19, 2014), *available at* http://www.mass.gov/anf/docs/hpc/20140219-final-cmir-report-phs-ssh-hmc.pdf [hereinafter HPC PARTNERS-SOUTH SHORE FINAL REPORT]; *see also* COMMONWEALTH OF MASSACHUSETTS, HEALTH POLICY COMMISSION, REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITION OF HALLMARK HEALTH CORPORATION, (HPC-CMIR-2013-4): FINAL REPORT (Sept. 3, 2014), *available at* http://www.mass.gov/anf/docs/hpc/material-change-notices/phs-hallmark-final-report-final.pdf [hereinafter HPC PARTNERS-HALLMARK FINAL REPORT].

[7] We understand that the HPC has submitted comments to the Court on the Proposed Consent and encourage the Court and all interested participants to review their detailed findings. Massachusetts Health Policy Commission, Public Comment by the Massachusetts Health Policy Commission In Re Commonwealth of Massachusetts v. Partners Healthcare System, Inc., South Shore Health and Educational Corporation, and Hallmark Health Corporation, Superior Court Civil Action No. 14-2033-BLS (July 17, 2014), *available at* http://www.mass.gov/anf/docs/hpc/hpc-submission-into-court-authorized-public-comment-period.pdf [hereinafter HPC Public Comments]; *see also* HPC PARTNERS-HALLMARK FINAL REPORT, *supra* note 6, Ex. B at 1 ("This transaction is projected to reinforce Partners' market power and increase medical spending in northeastern Massachusetts, notwithstanding the proposed settlement and current payer contract provisions. The parties have not provided reliable and concrete evidence of care delivery efficiencies that would offset these costs.").

[8] Emerson Hospital, which Partners has not officially proposed to acquire or been reviewed by the HPC, is also potentially included.

Compounding the problems identified by the HPC, the Proposed Consent would impose only conduct (or behavioral) remedies—rather than stopping the acquisitions outright or requiring *any* divestitures, the latter being the most common concessions defendants make to close investigations and consummate proposed business combinations without litigation. Conduct remedies are disfavored because they are hard to administer and often ineffective. And the conduct remedies in the Proposed Consent, in particular, are destined to be especially ineffective because none is tied directly to the root *cause* of Partners' ability to raise prices and otherwise inflict harm on consumers and the community, i.e., to its market power. Instead, each attempts to put in place measures indirectly aimed at reducing but not eliminating the anticompetitive *effects*. As bad, as we explain below, each remedy is destined to fail in the long-term.

Because these remedies do not address the factors that actually contribute to Partners' market power, they cannot prevent the myriad forms of price increases that would inevitably occur. For example, consumers in the Commonwealth would—ultimately—pay more for their health care in the form of increased health insurance premiums as Partners, the highest-cost market participant, expands further under the terms of the Proposed Consent. As employers continue to respond to premium increases by cost-shifting to their employees, consumers would be required to pay an ever-increasing portion of the higher premiums and be offered plans with higher co-pays and deductibles, resulting in higher out-of-pocket costs to consumers. Money paid by employers for higher premiums would not be available for wage increases, resulting in depressed wages. Moreover, each restriction would only be in place for a handful of years. Once the terms of the Proposed Consent expired, Partners would have fully entrenched itself as the largest, richest, and most powerful health care system in the Commonwealth—one largely

immune from the effects of competition which could benefit consumers in the Commonwealth.

The Proposed Consent's remedies have numerous fundamental flaws. Apart from ignoring the most obvious remedy and the only one likely to work—simply blocking the acquisitions outright—there are some significant misunderstandings and errors imbedded in the remedies, including:

- *First*, the **component contracting provisions** lack a practical connection with the actual Payer contract negotiation process. Because Partners would continue to own each component, it would have no incentive to allow the components to compete aggressively with one another. Instead, it is far more likely that Partners would be able to continue to exploit its market power through its individual components. Additionally, Payers would only gain meaningful leverage in negotiations with Partners if they could credibly threaten to offer plans that do not include Partners components, such as Massachusetts General Hospital or Brigham and Women's Hospital, which Payers simply could not do (even with respect to the components that do not include the flagship teaching hospitals) without threatening their own market position and harming their own enrollees.[9] And contracting with individual components, rather than with one comprehensive entity, would significantly increase transaction costs for the Payers, reducing or eliminating any potential cost savings. Moreover, the components are not structured in a way that would or could allow the Payers, even if interested, to design limited network products that could provide coordinated care across components

[9] *See* Editorial Board, *The Risks of Hospital Mergers*, NY TIMES, July 6, 2014, *available at* http://www.nytimes.com/2014/07/07/opinion/the-risks-of-hospital-mergers.html?_r=0 ("The bargaining power of [Partners] was starkly displayed in 2000 when the Tufts Health Plan refused to pay Partners what it considered unjustifiably high prices. Partners promptly announced it would no longer accept Tufts insurance and created an uproar among members of the Tufts plan who wanted to retain access to the two prestigious hospitals [Massachusetts General Hospital and Brigham and Women's Hospital]. Faced with defections that could destroy its viability, Tufts quickly caved in.").

- *Second*, the **price growth caps** would do nothing to remedy the current disparity between Partners' prices and those of its competitors. Due to the ambiguity and complexity of these provisions, Partners could actually *increase* this disparity while the remedy remains in effect. For instance, as developed below, Partners could offset increased prices in growing business lines with decreased prices in shrinking business lines to circumvent the unit price growth cap and increase overall prices at a rate greater than inflation. Moreover, these price growth caps would not change the long-term underlying dysfunction in the Massachusetts health care services market, in which Partners uses its market power to obtain the highest available rate increases—as the Attorney General has documented in her Examinations of Healthcare Cost Trends and Cost Drivers[10]—while all of its competitors must settle for lower rate increases from the Payers' depleted purses. And the TME[11] is focused only on 11 percent of Partners' revenues (its risk contract revenues)—not upon all its commercial revenues, which are predominantly paid on a fee-for-service basis.[12] It is important to note that as soon as the terms of the price growth caps expire, Partners would be free to raise its rates with impunity.
- *Third*, the **physician growth restrictions** would only be in place for five years and would give Partners the ability to hire (or otherwise contract with) hundreds more

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[10] 2013 COST DRIVERS REPORT, *supra* note 3; OFFICE OF ATTORNEY GENERAL MARTHA COAKLEY, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L. C. 118G, § 6½(B): REPORT FOR ANNUAL PUBLIC HEARING, at 15–16 (June 22, 2011), *available at* http://www.mass.gov/ago/docs/healthcare/2011-hcctd-full.pdf; OFFICE OF ATTORNEY GENERAL MARTHA COAKLEY, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L. C. 118G, § 6 ½(B): REPORT FOR ANNUAL PUBLIC HEARING, at 10–16 (Mar. 16, 2010), *available at* http://www.mass.gov/ago/docs/healthcare/final-report-w-cover-appendices-glossary.pdf.

[11] TME stands for "total medical expenses," as defined in Attachment A to the Proposed Consent; *see also infra* App'x § B(2)(1).

[12] *See* Commonwealth of Massachusetts, Health Policy Commission, Annual Cost Trends Hearing (2013), Pre-Filed Written Testimony of Partners HealthCare System, Response to Ex. C, Q. 5 (2013), *available at* http://www.mass.gov/anf/docs/hpc/attachment-b-for-phs.xlsx (latest data Partners publicly filed, indicating the commercial risk business monitored by the TME provision of the Proposed Consent would cover approximately 11 percent of Partners' total commercial business); HPC Public Comments, *supra* note 7, at 4 n.7 & 16.

community physicians than it does today and impose no limits at all on the hiring of academic specialists in the Metro Boston area (though there are some modest limits regarding academic primary care physicians). It is difficult to conceive how this provision would be a "restriction" at all, and after just five years, Partners would be entirely unrestricted in the physician market. It is physicians who refer patients (consumers) to hospitals and other facilities for treatment, and, therefore, controlling more physicians is a key aspect of Partners' ability under the Proposed Consent to further expand its dominant market power.

- *Finally*, the **proposed conduct remedies** and the terms surrounding them are incomplete, complex, and ambiguous, meaning that monitoring Partners' compliance with the proposed remedies would involve significant efforts on behalf of the Compliance Monitor and the Court during the ten-year life of the Proposed Consent. The substantial and ongoing burdens for this Court in ensuring compliance could be enormous.

Given the inherent inability of the remedies proposed in the Proposed Consent to address effectively the significant harms associated with these hospital and physician acquisitions, a careful examination of the Proposed Consent is essential to ensuring that the public interest would be served by its implementation, if approved by this Court.

We understand that the Court generally owes deference to the conclusions of the Attorney General. When, however, the Attorney General purports to utilize unorthodox and untested remedies to address the complex anticompetitive effects that would result from the proposed acquisitions as part of a settlement, the Court can and should inquire into precisely how the proposed remedies would address the significant consumer harms identified by the Attorney

General herself.

As we explain more fully below in Section II, courts consider several factors in analyzing whether to enter a proposed consent decree because there is a strong and longstanding recognition that courts must conduct their own independent inquiry into whether a proposed consent is in the public interest. Courts frequently request additional and specific information from the parties explaining precisely why their proposed consents are in the public interest, especially when the proposed remedies deviate from those most frequently used or it is unclear how the remedies would address the problems identified. And when the answers to those questions fail to address the underlying problems, the courts are free to simply say: "no."

The Proposed Consent is a perfect example of such a situation, and the Court, accordingly, is well within its discretion to question the Attorney General as to exactly how she expects the proffered remedies would prevent the significant anticompetitive effects that the Attorney General identified in her Complaint and that the HPC identified in its cost and market impact reviews, as well as why she believes the temporary conduct remedies are preferable to permanent structural remedies that are commonly imposed in settling similar antitrust cases nationwide. The answers, unfortunately, will provide no comfort.

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This submission is divided into several sections. In Section II, we offer an explanation of the appropriate standard of review and explain why this Court is not simply a "rubber stamp" that is compelled to approve the Proposed Consent without giving full and thoughtful consideration to its profound, wide-ranging, and long-term consequences for consumers in the Commonwealth. In Section III, we offer a series of important questions regarding the operation of the Proposed Consent that we believe must be answered before this Court can make a final

determination that the Proposed Consent is in the public interest. In Sections IV – VI, we provide detailed examinations of each of the so-called remedies and the many uncertainties and gaps created by the Proposed Consent as to component contracting, price growth restrictions, and provider contracting and growth restrictions. Finally, we offer a summary of the Proposed Consent's provisions in an appendix.

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We encourage this Court to reject the Proposed Consent because it does nothing to remedy, and in fact would increase in a material way, the significant anticompetitive harms in the form of higher costs that Partners has inflicted on the citizens of the Commonwealth. We thank the Court for the opportunity to provide comments and we look forward to discussing our concerns further at the hearing.

II. THE STANDARD OF REVIEW

This Court's authority absolutely extends to a determination of whether the Proposed Consent is fair, reasonable, and in the public interest.[13] While giving deference to the Attorney General is appropriate, the Court must make its own inquiry into whether the consent satisfies these factors and must not "blindly follow[] the agency's lead" or "rubberstamp" the Attorney General's proposal.[14] The Court has authority to approve, to deny approval outright, or to deny with a set of modifications that, if made, would garner approval.[15]

A. This Court must determine whether the Proposed Consent is fair, reasonable, and in the public interest, and should afford the Attorney General less deference here than it would if an expert agency were analyzing a case with no factual findings.

Generally, this Court must determine whether the Proposed Consent is fair, reasonable, adequate, and in the public interest.[16] In rendering this determination, this Court does not consider whether the settlement is one the Court itself would have reached or whether the Court thinks the settlement is ideal.[17] Although the First Circuit has recognized a "strong public policy in favor of encouraging settlements, particularly in very complex and technical regulatory contexts" where the government is a party, this policy does not mean the Court abdicates its responsibility to determine whether the consent is in the public interest.[18]

In evaluating a proposed consent decree, courts afford deference to the conclusions of the

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[13] *See Conservation Law Found. of New England, Inc. v. Franklin*, 989 F.2d 54, 58–59 (1st Cir. 1993).
[14] *F.T.C. v. Standard Fin. Mgmt. Corp.*, 830 F.2d 404, 408 (1st Cir. 1987).
[15] *See United States v. Microsoft Corp.*, 56 F.3d 1448, 1462 (D.C. Cir. 1995); *F.T.C. v. Circa*, No. 11-2172, 2012 WL 2178705, at *5 (D.N.J. June 13, 2012).
[16] *United States v. City of Portsmouth, N.H.*, No. 09-CV-283-PB, 2013 WL 595929, at 2 (D.N.H. Feb. 15, 2013); *Conservation Law Found. of New England, Inc.*, 989 F.2d 58–59 ("District courts must review a consent decree to ensure that it is 'fair, adequate, and reasonable; that the proposed decree will not violate the Constitution, a statute or other authority; [and] that it is consistent with the objectives of Congress.'" (quoting *Durrett v. Housing Authority of Providence*, 896 F.2d 600, 604 (1st Cir. 1990))).
[17] *City of Portsmouth*, 2013 WL 595929 (citing *United States v. Cannons Eng'g Corp.*, 899 F.2d 79, 84 (1st Cir.1990)).
[18] *See United States v. Comunidades Unidas Contra La Contaminacion*, 204 F.3d 275, 280 (1st Cir.2000); *Conservation Law Found.*, 989 F.2d at 59; *Cannons Eng'g*, 899 F.2d at 84.

agency and the private party, but are not passive "rubberstamps." As the First Circuit has noted, "[t]hough the court should accord some substantial deference to the agency's determination that the settlement is appropriate it must not let judicial inertia take hold."[19] A court "must make its own inquiry into the issue of reasonableness before entering judgment."[20]

The specific level of deference owed to the Attorney General here is less than in typical instances in which courts have reviewed proposed consent decrees. To a large extent, the deference owed is a function of the fact that, typically, "there are no *findings* that the defendant has actually engaged in illegal practices."[21] Here, however, this general principle does not hold true. The Attorney General's complaint concludes the proposed acquisitions will substantially harm competition and result in increased health care prices in the Commonwealth. And the HPC's in-depth, expert analysis bears these conclusions out.[22] The HPC is a specialized, independent state agency tasked with evaluating transactions among health care providers and rendering just such findings. The HPC conducted its own initial analysis and reached preliminary conclusions, then evaluated the parties' counterarguments and proffered efficiencies, and finally rendered its conclusions. The HPC found that the two acquisitions were likely to substantially raise prices in the Massachusetts health care services market. There are, therefore, findings that the proposed merger clearly violates antitrust laws.

Given these findings, a fundamental component of this Court's responsibility now is to

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[19] *F.T.C. v. Standard Fin. Mgmt. Corp.*, 830 F.2d at 408.
[20] *Id.* (citing *Bureau of Alcohol, Tobacco & Firearms v. FLRA*, 464 U.S. 89, 96–98 (1983)).
[21] *United States v. Microsoft Corp.*, 56 F.3d 1448, 1460–61 (D.C. Cir. 1995).
[22] *See* HPC PARTNERS-SOUTH SHORE FINAL REPORT, *supra* note 6, at 58; HPC PARTNERS-HALLMARK FINAL REPORT, *supra* note 6, at 2–3; *see also* COMMONWEALTH OF MASSACHUSETTS, HEALTH POLICY COMMISSION, REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITIONS OF SOUTH SHORE HOSPITAL (HPC-CMIR-2013-1) AND HARBOR MEDICAL ASSOCIATES (HPC-CMIR-2013-2): PRELIMINARY REPORT, at 29–45 (December 18, 2013); COMMONWEALTH OF MASSACHUSETTS, HEALTH POLICY COMMISSION, REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITIONS OF HALLMARK HEALTH CORPORATION (HPC-CMIR-2013-4): PRELIMINARY REPORT, at 41–55 (July 2, 2014).

examine the nuances of the proposed remedy to determine if the alleged "fixes" will address the violations found.[23]

As an initial matter, the Attorney General does not have the significant expertise in remedying anticompetitive mergers as does the Antitrust Division of the United States Department of Justice ("DOJ") or the Federal Trade Commission ("FTC"). Enforcing antitrust laws is merely one of her myriad tasks. And there is no comprehensive regulatory framework governing antitrust violations.

Not only does the Attorney General lack this particularized antitrust knowledge, she was at a distinct disadvantage in negotiating with Partners, and while the proposed remedies may seem facially appealing, they are impotent to control Partners' monopolistic exploitation in practice. Accordingly, deference to the Attorney General's proposed remedies in an antitrust matter like this one should be limited.[24] The overall deference afforded the Proposed Consent should be lesser than where an agency with significant expertise is settling claims not rigorously evaluated—as neither of these common factors is present.

B. In making this determination, courts typically consider many factors, including the efficacy of the proposed remedies.

Courts consider numerous factors in reviewing proposed consent decrees, one of the most important being the ability of the proposed remedies to alleviate the identified harms.[25] In the

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[23] *See United States v. Microsoft Corp.*, 231 F. Supp. 2d 144, 153 (D.D.C. 2002) ("Given the liability findings, part of the public interest analysis will require consideration of the extent to which the proposed consent decree 'meets the requirements for an antitrust remedy.'" (quoting *United States v. AT&T*, 552 F. Supp. 131, 153 (D.D.C. 1982))); *New York v. Microsoft Corp.*, 231 F. Supp. 2d 203, 210 (D.D.C. 2002) (same).

[24] *See, e.g., City of Bangor v. Citizens Commc'ns Co.*, 532 F.3d 70, 94 (1st Cir. 2008) (recognizing the state agency had "some expertise" and according "some deference to Maine's decision to sign onto the Consent Decree, but not the same amount of deference we would accord the EPA in a consent decree involving the United States"): *Cannons Eng'g Corp.*, 899 F.2d at 84 ("[T]he true measure of the deference due depends on the persuasive power of the agency's proposal and rationale, given whatever practical considerations may impinge and the full panoply of the attendant circumstances[.]").

[25] *See, e.g., United States v. Cannons Eng'g Corp.*, 720 F. Supp. 1027, 1038 (D. Mass. 1989), *aff'd,* 899 F.2d 79 (1st Cir. 1990) (action under the Comprehensive Environmental Response, Compensation, and Liability Act

environmental context, for example, courts have repeatedly emphasized the importance of ascertaining "the degree to which the remedy provided for a consent decree will adequately address the hazards present at the site."[26] Similarly, in the antitrust context, specifically, many courts have recognized that "the Tunney Act permits the Court to consider, among other things, the relationship between the remedy secured and the specific allegations set forth in the government's complaint, whether the decree is sufficiently clear, **whether enforcement mechanisms are sufficient, and whether the decree may positively harm third parties.**"[27] Here, the efficacy of the proposed remedies is a serious question. The Court need not merely take the Attorney General's word that unprecedented remedies will sufficiently protect the public interest.

The Court's hands are not bound so tightly as the Attorney General and defendants here suggest. The Court can—and should—inquire into the ability of the proposed remedies to alleviate the competitive concerns the Attorney General identified in her complaint.[28] The *SEC v. Citigroup* case upon which the parties rely is distinguishable for several important reasons.[29] *First*, in that case the court found "the district court made *no findings* that the injunctive relief proposed in the consent decree would disserve the public interest, in part because it defined the

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("CERCLA"), noting courts consider "several criteria" in determining a consent's reasonableness, including "the degree to which the remedy provided for a consent will adequately address the hazards present"); *see also United States v. 3M Co.*, No. 3:14-CV-32, 2014 WL 1872914 (S.D. Ohio May 8, 2014) (same); *United States v. Azco Coatings of America, Inc.*, 949 F.2d 1409, 1436 (6th Cir. 1991) (citing *Cannons Eng'g Corp.*, 720 F. Supp. at 1038).

[26] *See supra* note 25.

[27] *United States v. Archer-Daniels-Midland Co.*, No. CIV.A. 02-1768, 2003 WL 21976063 (D.D.C. July 22, 2003) (emphasis added); *see also Microsoft*, 56 F.3d at 1462 ("When the government and a putative defendant present a proposed consent decree to a district court for review under the Tunney Act, the court can and should inquire . . . into the purpose, meaning, and efficacy of the decree.").

[28] *See Microsoft*, 56 F.3d at 1462.

[29] *SEC v. Citigroup Global Markets, Inc.*, 752 F.3d 285 (2d Cir. 2014).

public interest as 'an overriding interest in knowing the truth.'"[30] Here, to the contrary, we are not arguing the public interest is disserved because the truth has not been revealed, but rather because the proposed conduct remedies are not effective. These remedies, all of which are merely temporary, would allow Partners to acquire substantial additional market share and further exercise its market dominance, resulting in significant harm to the public in the form of higher prices for health care services in the Commonwealth.

Second, although *Citigroup* stated that "determining whether the proposed S.E.C. consent decree best serves the public interest . . . rests squarely with the S.E.C.," it further held that, "[o]n remand, the district court should consider whether the public interest would be disserved by entry of the consent decree."[31] So even that court recognized that each court must conduct its own inquiry as to the consent's effect on the public interest. *Finally*, the SEC is an expert agency that is "free to eschew the involvement of the courts and employ its own arsenal of remedies" if it so chooses.[32] The Attorney General, however, does not have this option nor this expertise—any consent she reaches must always be approved by a court. And the Attorney General is not a typical expert antitrust agency.

C. Courts may and do request explanations of proposed remedies when they are unorthodox or when it is not clear how the remedies will address the identified problems.

Courts may express concerns with consent decrees as originally presented and request explanations and/or additional information or briefing to alleviate their concerns. Courts must have this ability if they are to avoid being mere rubber stamps. Without the capacity to express hesitation regarding terms and to request explanation, courts could exert no meaningful review.

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[30] *Id.* at 297 (emphasis added).
[31] *Id.* at 296–97.
[32] *Id.* at 285.

Courts have frequently declined to immediately enter a proposed consent, requiring the parties to alter terms or explain how the consent was in the public interest.[33] For example, in *United States v. City of Akron*,[34] the court refused to approve the consent decree until after its concerns were satisfactorily addressed. That court initially found the proposed consent decree was "not fair, reasonable, adequate, and in the public's best interest,"[35] due to "the parties' inability to clearly and concisely explain how its terms were reached," "why the duration of the decree varied so far from EPA guidance," and to "explain in full the funding choices that were explored when

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[33] *See, e.g., Ibarra v. Texas Employment Comm'n*, 823 F.2d 873, 874 (5th Cir. 1987) (reversing district court's judgment entering a consent decree between the Texas Employment Commission and plaintiff class of aliens, defining what categories of aliens were "permanently residing in the United States under color of law"); *United States v. Am. Tel. & Tel. Co.*, 552 F. Supp. 131, 151 (D.D.C. 1982), *aff'd sub nom. Maryland v. United States*, 460 U.S. 1001, 103 S. Ct. 1240, 75 L. Ed. 2d 472 (1983), (modifying the government's and defendants' modified proposed consent, and noting courts need not "unquestioningly accept a proffered decree as long as it somehow, and however inadequately, deals with the antitrust and other public policy problems implicated in the lawsuit"); *Environmental. Tech. Council v. Browner*, No CIV. A. 94-2119, 1995 WL 238328 (D.D.C. Mar. 8, 1995) (declining to enter the proposed consent because it "may not be consistent with the public interest," and "allow[ing] the EPA and the settling plaintiffs to submit a revised proposed consent decree that addresses the Court's concerns about the enforceability of the proposed consent decree's deadlines"); *United States v. Telluride Co.*, 849 F. Supp. 1400, 1406 (D. Colo. 1994) (denying proposed consent and concluding "the proposed consent decree is not fair, reasonable and equitable and that it does not satisfactorily uphold the public's interest"); *State of Utah ex rel. Utah State Dep't of Health v. Kennecott Corp.*, 801 F. Supp. 553, 572 (D. Utah 1992), *appeal dismissed* 14 F.3d 1489 (10th Cir. 1994), (denying proposed consent and concluding "the proposed Consent Decree as written is not just and fair or consistent with the purposes of CERCLA"); *Pennsylvania Environmental Defense Foundation v. Bellefonte Borough*, 718 F. Supp. 431 (M.D. Penn. 1989) (refusing to enter proposed consent that did not comport with EPA's mitigation project rule for remedying the violations at issue); *E.E.O.C. v. Pan Am. World Airways, Inc.*, 622 F. Supp. 633 (N.D. Cal. 1985), *appeal dismissed* 796 F.2d 314 (9th Cir. 1986) (refusing to enter consent decree); *Comm'r of Dep't of Planning & Natural Res. v. Century Alumina Co.*, No. CIV. 2005/0062, 2008 WL 4693550 (D.V.I. Oct. 22, 2008) (unpublished) (denying proposed consent decree because the "proponents have failed to meet their burden of producing evidence which enables the court to determine independently whether the proposed Consent Decree is fair, reasonable, and consistent with the goals of CERCLA"); *United States v. Pesses*, No. CIV. A. 90-654, 1994 WL 741277 (W.D. Pa. Nov. 7, 1994) (unpublished) (denying proposed consent and noting "the court must conduct an independent evaluation of the evidence relied upon in relation to the agreements reached and must eschew any rubber stamp approval of it"); *see also CoStar Group, Inc., Lonestar Acquisition Sub, Inc. & LoopNet, Inc.*, FTC No. 111-0172 (Aug. 30, 2012) (merger case, modifying consent decree in response to concerns addressed in public comments), http://www.ftc.gov/news-events/press-releases/2012/08/ftc-approves-modified-final-order-settling-charges-costars-860; *United States v. Chevron U.S.A., Inc.*, 380 F. Supp. 2d 1104, 1121 (N.D. Cal. 2005) (noting the important role amici played in evaluating the proposed consent: "[b]ecause of their comments, the Court has applied much closer scrutiny than would have otherwise been possible," and amici drew "the Court's attention to those issues that are the most problematic, while also assisting in the Court in navigating the complicated regulatory landscape on which the Consent Decree sits").

[34] *United States v. City of Akron*, 794 F. Supp. 2d 782 (N.D. Ohio 2011).

[35] *Id.* at 808.

examining the financial burden created by the Decree."[36] Later, the court held a renewed fairness hearing, with nearly six hours of testimony, after which it appointed an expert to evaluate the consent. This expert "provided precisely what th[e] Court ha[d] sought," and the court could finally conclude the decree was "fair, adequate, and reasonable, as well as consistent with the public interest."[37]

Here, as in *Akron*, the proposed conduct remedies are far afield from the structural remedies traditionally utilized in antitrust cases. The Court would be well within its discretion to request the Attorney General explain explicitly how she anticipates these unorthodox, untested remedies will prevent the significant consumer harms both she and the HPC identified.[38]

D. Consummation of the 1994 Mass General and Brigham & Women's Hospital Merger Should Not Bar Appropriate Relief Here

While criticism of the pending mergers and proposed settlement is nearly universal, some have suggested that part of the problem lies with the 1994 merger of Massachusetts General Hospital and Brigham and Women's Hospital being allowed to proceed.[39] But that this prior merger was allowed is an additional reason for blocking the currently proposed mergers, not a reason for allowing them.[40] There is nothing prohibiting the Attorney General, even now, from seeking relief from (or even undoing) the 1994 transaction. It has long been settled law under the Clayton Act (which the Attorney General may invoke) that, although "[t]he legality of a particular transaction usually is determined as of the time it occurs, [it] also may be determined

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[36] *United States v. City of Akron*, No. 5:09CV272, 2014 WL 202708, at *2 (N.D. Ohio Jan. 17, 2014).
[37] 2014 WL 202708, at *2.
[38] *See also FTC v. Circa*, No. 11-2172, 2012 WL 2178705 at *5 (D.N.J. June 13, 2012) (the court requested additional briefing from the FTC and the defendant to explain the standard of review and why the consent decree was in the public interest).
[39] *See, e.g.*, Editorial Board, *The Risks of Hospital Mergers*, NY TIMES, July 6, 2014, *available at* http://www.nytimes.com/2014/07/07/opinion/the-risks-of-hospital-mergers.html?_r=0.
[40] *See id.* (describing the settlement here as "a dubious bargain").

as of the time of any suit challenging the merger."[41] In the leading case of *United States v. E.I. duPont de Nemours & Co.*,[42] for example, duPont's 1917 acquisition of stock in General Motors was successfully challenged 30 years later, and divestiture was ordered.[43] The 1994 transaction, therefore, provides no excuse for throwing up one's hands and claiming "it can't be done." In fact, it behooves the Court to ensure that the market power established beginning in 1994 does not continue to go unchecked to the detriment of the community.

[41] ABA SECTION OF ANTITRUST LAW, ANTITRUST LAW DEVELOPMENTS 338–39 (7th ed. 2012).
[42] 353 U.S. 586, 597 (1957).
[43] *Accord United States v. ITT Cont'l Baking Co.*, 420 U.S. 223, 241 (1975).

III. THE QUESTIONS THAT MUST BE ASKED

A. Conduct Remedies and Antitrust Law

A threshold question the Court should remember in analyzing the Proposed Consent is why, faced with conclusions from state agencies that the acquisitions at issue would substantially increase costs in the already high-cost Massachusetts health care services market, the Attorney General elected to allow the acquisitions to proceed with only conduct, or behavioral, remedies to limit their anticompetitive effects. Structural remedies, such as blocking acquisitions and divestiture, are the typical, favored antitrust remedies for alleviating the harms associated with anticompetitive mergers.[44] Behavioral remedies, on the other hand, are disfavored in antitrust law, because they are "inferior substitute[s] for allowing competition," that "nearly always focus on price, ignoring the impact of a transaction on quality improvements or innovation."[45]

Most of the conduct remedies proposed here will have no real impact because they are out of touch with market realities. The conduct remedies here are complex and ambiguous, making them even more difficult to administer and likely to fail. They are also only temporary, applying for just a few years and making the structural problems worse by allowing Partners to

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[44] *See, e.g., United States v. E.I. du Pont de Nemours & Co.*, 366 U.S. 316, 329 (1961); *St. Alphonsus Medical Center – NAMPA, Inc. v. St. Luke's Health System, Ltd.*, No. 14-35173, Answering Brief for Plaintiffs/Appellees the Federal Trade Commission and the State of Idaho (Dkt. No. 72-1) (9th Cir. Aug. 13, 2014), *available at* http://www.ftc.gov/system/files/documents/cases/140813stlukeansweringbrief.pdf ("The very words of Section 7 suggest that an undoing of the acquisition is the natural remedy." (quoting *E.I. du Pont*, 366 U.S. at 329)); U.S. DEP'T OF JUSTICE, ANTITRUST DIVISION, ANTITRUST DIVISION POLICY GUIDE TO MERGER REMEDIES (2011), *available at* http://www.justice.gov/atr/public/guidelines/272350.pdf.

[45] Speech by Deborah L. Feinstein, Director, Federal Trade Commission Bureau of Competition, Antitrust Enforcement in Health Care: Proscription, not Prescription, at the Fifth National Accountable Care Organization Summit – Washington, DC, at 15 (June 18, 2014), *available at* http://www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf. While the Director recognized that behavioral remedies may be more appropriate when a state regulatory scheme comprehensively addresses the behavior at issue, the Massachusetts framework does not come close to fitting within the mold the Director had in mind. *See Id.* at 16 n.44. Massachusetts law provides the HPC with only the power to *advise*—and its advice has been largely ignored here. The Director was referring to more comprehensive regulatory frameworks, such as that established in Maryland, where prices and various other market aspects are directly established and regulated by statute. *See* MD. Code Title 19, Subtitle 2. Indeed, the whole point of her presentation was to explain how inappropriate the types of remedies proposed here truly are.

add several hospitals and hundreds of physicians. It is entirely unclear to us why, when presented with a compelling factual landscape—namely, Partners as a dominant entity extracting monopoly prices (far higher than its next closest competitors without attendant quality benefits) thereby absorbing larger and larger chunks of the Commonwealth's health care funding—the Attorney General chose not to seek structural relief in the form of blocking the proposed acquisitions or even divestiture of existing Partners entities, but instead, presents the Court with only disfavored conduct remedies. This decision is especially surprising given the proposed conduct remedies would essentially authorize an ambitious growth plan for what is already by far the largest health care system in the Commonwealth. Under the antitrust laws, the Attorney General could have sued to block these proposed acquisitions or even to "break up" Partners. Antitrust law has long contemplated that antitrust enforcement includes "undoing" long-completed transactions where the anticompetitive effects, as in this case, have been clearly demonstrated. However, instead of trying to directly address the sources of Partners' market power by freezing or reducing its size and market share, the Attorney General is asking this Court to approve a substantial increase in the great size and market share Partners currently enjoys.

With this context in mind, we believe it is incumbent upon the Attorney General to provide the Court with an explanation of why and how the conduct remedies proposed here are superior to structural relief that could have been achieved through litigation, or even just as part of an effective consent judgment. Given Partners' history of anti-competitive behavior, well-documented in the Attorney General's own health care Cost Driver reports,[46] we are at a loss to understand the Attorney General's reasons for not demanding structural relief. The Attorney

[46] *See supra* note 10.

General has proffered the often-used "hazards of litigation" defense in structuring and agreeing to the Proposed Consent with Partners. However, the proposed remedies in this case are so weak and ineffectual that we strongly believe the adverse consequences to the citizens of Massachusetts between the Attorney General litigating and losing an antitrust case against Partners, on the one hand, and this Court's acceptance of the Proposed Consent, on the other, would be negligible.

B. Component Contracting[47]

The component contracting remedy as proposed would utterly fail to achieve its intended result of mitigating the cost-increasing impacts of Partners' market power. First, for the reasons set forth in more detail in Section IV below, component contracting is a novel and strongly disfavored conduct remedy with no track record of success in Massachusetts or elsewhere in the United States. Second, by permitting the same individuals reporting to the same leadership to continue to negotiate all of the Payer contracts and establish margin or price hurdles regarding the separate contracting components, the Proposed Consent places no meaningful restrictions on Partners' ability to continue to effectively use its overall market power to negotiate higher prices and other favorable contract terms.[48] Most obviously, component contracting is only effective if Payers are willing to leave a Partners entity out of one of its health plan products. History has shown the Payers are not willing to do this because the employers and consumers on whose behalf they contract will not accept health insurance products that exclude Partners' flagship hospitals or regionally dominant providers like South Shore Hospital. We also note that the

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[47] *See infra* App'x § A for an explanation of the Proposed Consent's component contracting provisions.

[48] As the HPC noted, for many patients, even if one Partners component were excluded, the next best option would be another Partners component, meaning that patients (and their checkbooks) would simply go from one Partners component to another—a "fact [that] contradicts the parties' claims that they would be unable to seek supra-competitive rates due to the threat of exclusion of Hallmark and 'the loss of potentially substantial amounts of revenue.'" HPC PARTNERS-HALLMARK FINAL REPORT, *supra* note 6, Ex. B at 6.

composition of the components themselves lead to some counterintuitive outcomes.[49] For example, because the AMC Contracting Component includes all facilities (wherever located) on an AMC's license, it includes some very substantial community-based facilities, including: (1) the Massachusetts General/North Shore Center for Outpatient Care in Danvers, Massachusetts; (2) Massachusetts General West in Waltham, Massachusetts; and (3) Brigham and Women's/Massachusetts General Health Care Center in Foxboro, Massachusetts.[50]

To allow this Court to make a determination that the Proposed Consent's component contracting terms are in the public interest, we believe the Attorney General must respond to each of the following material questions:

1. To the best of our knowledge, component contracting has never been a remedial tool in an antitrust action—save for one Federal Trade Commission action in the mid-2000s where it was included but never used by the Payers, and has since been disavowed.[51] Lacking any historical example of component contracting's potential success, on what basis did the

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[49] As the HPC points out, the components as structured "may present care coordination and referral challenges for both consumers and providers, especially in the context of a shift to global payment arrangements, which generally seek to reimburse providers for coordinating care across their entire networks." HPC PARTNERS-HALLMARK FINAL REPORT, *supra* note 6, Ex. B at 6.

[50] MGH West, for example, has 4 operating rooms that, alone, total 28,200 square feet. *See* Massachusetts Development Finance Agency, Notice of Public Hearing on Dec. 11, 2013, at 3–4, *available at* http://www.massdevelopment.com/wp-content/uploads/2013/11/partners_12112013.pdf. North Shore Danvers has 122,000 square feet of multispecialty ambulatory space. *See Mass General/North Shore Center for Outpatient Care Opens*, MASSACHUSETTS GENERAL HOSPITAL (June 5, 2009), http://www.massgeneral.org/obgyn/news/newsarticle.aspx?id=1733. And Brigham and Women's/ Mass General's Foxboro site constitutes another 93,000 square feet. *See About this Center: Brigham and Women's / Mass General Health Care Center*, MASS GENERAL ORTHOPAEDICS SPORTS PERFORMANCE CENTER, https://www.massgeneralsportsperformance.org/content/name/about/brigham-womens-mass-general-health-care-center (last visited Sept. 2, 2014).

[51] Even the one case in which the FTC utilized this remedy recognized that the rationale underlying the choice of remedy was unlikely to apply in future cases. *Opinion of the Comm'n, In the Matter of Evanston Northwestern Healthcare Corp.*, Docket No. 9315, at 90 (Aug. 7, 2008), *available at* http://www.ftc.gov/enforcement/cases-proceedings/0110234/evanston-northwestern-healthcare-corporation-enh-medical-group ("We note that our rationale for not requiring a divestiture in this case is likely to have little applicability to our consideration of the proper remedy in future challenges to an unconsummated merger, including a hospital merger. . . . Nor will our reasoning here necessarily apply to consideration of the appropriate remedy in a future challenge to a consummated merger, including a consummated hospital merger.").

Attorney General conclude that component contracting would remedy the anticompetitive harms she alleged?

2. Component contracting is purely voluntary from each Payer's perspective. To what extent did the Attorney General explore the administrative challenges and associated transactional costs that Payers would incur should they choose to use component contracting? On what basis and to what extent is the Attorney General confident that any Payer would choose to avail itself of component contracting?
3. Does the Attorney General contemplate there would be firewalls (or other protocols) placed around the creation of Partners' contracting components to ensure there is no sharing of price and other competitively-sensitive information among the components? If there are no such protections, then the components remain free to tacitly collude with one another—each component will know all of the details of every other component's negotiations, and will neither need nor have the incentive to offer Payers better terms. If there are no protections or firewalls, on what basis did the Attorney General conclude that component contracting would lead to competitive bidding among the components? On what basis did she conclude that component contracting would differ in any meaningful way from Partners' current contracting practices?
4. Has the Attorney General considered the impact on consumers of the potential exclusion of certain Partners providers from some insurance products, through increased out-of-pocket health care costs in the form of increased cost-sharing, related to necessary care provided to them by out-of-network providers? If so, has the Attorney General estimated the projected impact of these exclusions from Payers' networks or otherwise considered how to mitigate these additional burdens on consumers?

C. Price Growth Restrictions[52]

Price growth restrictions are similarly disfavored conduct remedies. The DOJ and the FTC have long recognized that such price restrictions are ineffective because they "represent a distinctly regulatory approach to what is, at bottom, a problem of competition—and that problem will remain after the commitment has expired."[53] Price growth restrictions are also ineffective in practice. As noted in HPC's final cost and market impact review of Partners' acquisition of the Hallmark Entities, when providers have been subject to a price growth cap, prices have usually risen after the cap's expiration.[54]

The price growth restrictions in the Proposed Consent suffer from four additional, significant flaws. First, they are very complicated and the Proposed Consent itself is ambiguous regarding how the calculations must be performed. This level of complexity and ambiguity—especially in light of the fact that Partners has primary responsibility for performing the calculations regarding the price growth restrictions—creates a serious question regarding the effectiveness of the price growth caps, and the ability of the Compliance Monitor to evaluate compliance, over the 6.5-year term of the caps.

Second, the unit price growth cap formula could enable Partners to circumvent the cap

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[52] *See infra* App'x § B for an explanation of the Proposed Consent's price growth restrictions.

[53] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, ch. 4, p. 29 (2004), *available at* http://www.justice.gov/atr/public/health_care/204694.pdf. We note that this document also states that "[n]evertheless, the Agencies realize that in some circumstances, State Attorneys General may agree to community commitments in light of the resource and other constraints they face." No one suggests here that the Commonwealth, which has placed health care at the forefront of its policy agenda, faces such resource constraints. The Agencies have made it clear that this type of remedy is one they will never pursue and that state AGs should adopt them only as a last resort in cases, unlike this one, where the harm is comparatively small and disproportionately small compared to the AG's cost of litigating.

[54] *See* HPC PARTNERS-HALLMARK FINAL REPORT, *supra* note 6, at 44 n.166 (citing Jeff Engel, *Spectrum Health, Metro Health, and St Mary's Are Charging More for Hospital Services*, GRAND RAPIDS PRESS, July 3, 2010, *available at* http://www.mlive.com/business/west-michigan/index.ssf/2010/07/spectrum_health_metro_health_a.html (describing the eight percent price increases implemented at Spectrum Health after the expiration of a seven year price growth cap set forth in *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285 (W.D. Mich. 1996))).

and increase prices at a rate faster than inflation. By applying prices for services in a particular year to the mix of services provided in the prior year, the formula determines a theoretical price increase and not the actual price increase experienced by Payers, risk-bearing provider networks, and patients. For example, if a particular segment of Partners' business is growing (and Partners, like all providers, has good information about these trends), Partners could negotiate a higher price increase for that segment and offset that price increase with a price decrease (or a smaller increase) in a segment of the market that trends show is shrinking. Since the rate of growth in Partners' prices is calculated based on the service mix in the baseline (prior) year, not the actual service mix in the measurement year, the result of such a strategy would be an effective overall price increase that is greater than inflation. Such a potential increase is shown in Exhibit A. The detailed information regarding which sectors are growing and which are shrinking would be available to just one party: Partners, who would have every financial incentive to maximize its price increase strategy in this way.

Third, and most importantly, even if the price growth caps were effective in slowing the growth of Partners' pricing, they would likely do nothing to narrow the already wide gap between Partners' prices and those of its competitors.[55] (As reported by the Attorney General in her cost-driver reports, this gap is not justified by the characteristics of Partners' patient population or the quality of Partners' services.[56]) Instead, the price growth "caps" would likely maintain, and probably lead to the further growth of, Partners' price advantage because Partners could still exploit its market power to obtain greater percentage increases than its competitors,

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[55] *See* HPC PARTNERS-SOUTH SHORE FINAL REPORT, *supra* note 6, at 14 n.40 (Feb. 19, 2014) ("From 2010 to 2012, each Partners hospital received the highest price among area hospitals from BCBS and THP, except for Cooley Dickinson (acquired by Partners in July 2013 and received the second highest price from BCBS) and Faulkner (received a lower price from THP). HPHC's prices for all of the Partners hospitals except Martha's Vineyard and Nantucket Cottage were consistently either the highest or second highest among area hospitals.").

[56] *See, e.g.*, 2013 COST DRIVERS REPORT, *supra* note 3, at 19.

who would continue to have to settle for lower rate increases each year.[57] This dynamic has already produced the highest per-capita health care costs in the nation and directly harmed Massachusetts consumers by means of ever-increasing health insurance premiums.[58] Partners' non-value-based price advantage has also made its competitors less able to compete effectively in terms of new facilities, facilities improvements, equipment acquisition, and physician recruitment and retention. Over time, these effects would likely further increase because the Proposed Consent does nothing to narrow Partners' price advantage.

Finally, the unit price growth cap implies there will be limits to the amount by which Partners' revenue increases—which would be consistent with the Commonwealth's goal of restraining increases to health care spending.[59] But this is not true. By shifting utilization from lower-priced to higher-priced facilities in Partners' network, Partners can achieve higher revenue—and health care spending in the Commonwealth will continue to increase drastically—even on the same basket of services and without direct price increases by Partners.[60] These increases in health care costs—driven by Partners— would continue to divert resources from other necessary infrastructure, including housing, education, and transportation, without any commensurate benefit to the Commonwealth.

To allow this Court to make a determination that the Proposed Consent's price growth

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[57] *See* HPC PARTNERS-HALLMARK FINAL REPORT, *supra* note 6, Ex. B at 4 ("[W]ithout lasting change to the market structures and incentives that underlie the operation of bargaining leverage, there are inherent limitations to the capacity of time-limited price constraints to contain costs long-term.").

[58] *See* 2013 COST DRIVERS REPORT, *supra* note 3, at 8–12.

[59] Indeed, the Proposed Consent contemplates price *increases* despite that the parties have "consistently advocated for the transaction on the basis that it will lower total medical spending." HPC PARTNERS-HALLMARK FINAL REPORT, *supra* note 6, Ex. B at 2. As such, the HPC has, unsurprisingly, chided the parties for failing to offer "an unequivocal commitment not to increase the prices of Hallmark providers and to lower total medical spending across all books of business for the operations and providers described in the parties transaction materials, whom they state will achieve this lowered spending." *Id.*; *see also id.* Ex. B at 15.

[60] *See* HPC PARTNERS-HALLMARK FINAL REPORT, *supra* note 6, Ex. B at 4 ("[T]he material price impact of anticipated shifts in patient are to higher-priced Partners providers is not fully addressed by the proposed settlement.").

restrictions are in the public interest, we believe the Attorney General must respond to each of the following questions:

1. How is it in the public interest to set the unit price growth cap at the level of inflation, thereby permitting Partners to continue extracting supra-competitive prices from Payers and locking in, or improving, its existing and substantial price advantage relative to other providers?
2. To what extent, if any, did the Attorney General investigate the actual level of increases that non-Partners providers have received recently?
3. On what basis is the Attorney General confident that Partners would not be able to take advantage of the unit price growth cap calculations to obtain price increases across all services greater than the rate of inflation?

D. Provider Contracting and Growth Restrictions[61]

The Proposed Consent's provider contracting and growth restrictions are not meaningful restrictions. The Proposed Consent would allow Partners to grow its existing community physician network from approximately 2,170 physicians to approximately 2,880 physicians—an increase of 33 percent—over the next five years.[62] This would allow Partners to hire (or otherwise contract with) an average of approximately 140 new physicians each year. And this estimate does not even include the additional 50-90 Academic Medical Center ("AMC") primary care physicians that Partners could add in the Metro Boston area under the separate cap applicable to AMC primary care physicians.

This growth means that Partners' network of community physicians alone would be

[61] *See infra* App'x § C for an explanation of the Proposed Consent's provider contracting and growth restrictions.
[62] We understand that approximately 400 community physicians would join Partners through South Shore PHO (including Harbor) as a result of Partners' proposed acquisition of the South Shore Entities.

substantially larger than the total (i.e., community and Boston-based) physician networks of each of its four principal competitors: BIDCO (approximately 2,300);[63] Steward Health Care Network (approximately 2,800);[64] Tufts (NEQCA) (approximately 1,800);[65] and Atrius Health (approximately 1,000).[66] Moreover, after five years, there would be no further restrictions on the growth of Partners' community physician network.

It is hard to understand why, faced with conclusive proof that Partners is already, and by far, the largest health care provider system in the Commonwealth and can uniquely extract monopoly rents, it should be entitled to such substantial *additional* growth. The so-called community physician *growth restriction* is, in fact, an ambitious Partners' community physician network *growth plan*. Moreover, we do not believe that these figures consider Partners' several thousand academic specialists, who only further compound Partners' domination of the market for health care services.

In addition, the Proposed Consent imposes no restrictions on the growth of Partners' specialists in Metro Boston, the most expensive group of physicians in the Commonwealth, which gives Partners opportunities to further increase its already substantial market power in this area by: (a) actively recruiting out-of-market specialists in key specialties; (b) actively recruiting in-market specialists currently employed by non-AMC competitors; and (c) responding to "unsolicited overtures" from specialists who currently work for Partners' competitor AMCs and then shifting more specialty care to Partners' high-cost specialists—resulting in significantly

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[63] *See* Press Release, Lawrence General Hospital & Beth Israel Deaconess Care Organization, Lawrence General Hospital and Beth Israel Deaconess Join Forces (May 7, 2014), *available at* http://www.bidpo.org/documents/LGH-BIDCO_5_6_14_FINAL.pdf.

[64] *See Home Page*, STEWARD HEALTH CARE NETWORK, http://www.steward.org/SHCN (last visited Sept. 2, 2014).

[65] *See Home Page*, NEW ENGLAND QUALITY CARE ALLIANCE (NEQCA) (AFFILIATED WITH TUFTS MEDICAL CENTER), http://www.neqca.org (last visited Sept. 2, 2014).

[66] *See Who We Are*, ATRIUS HEALTH, http://www.atriushealth.org/aboutUs/whoWeAre.asp (last visited Sept. 2, 2014).

increased costs.

The Proposed Consent would also require Partners to drop from its Payer Contracts physician groups that are neither employed by a Partners-controlled affiliate nor participating providers in a Partners hospital-affiliated AMC or Physician Hospital Organization ("PHO"). However, because Partners Contracting Affiliates are included in the baseline physician count (notwithstanding that their inclusion has been determined to be anticompetitive by the Attorney General), Partners could retain these groups, and add new ones, under the generous "caps" described above, so long as the groups join a Partners hospital PHO. To do so requires only that the group meet very modest geographical proximity and clinical integration requirements. These Partners hospital PHOs would include the PHO affiliated with the recently-acquired Cooley Dickinson Hospital and, post-closing, those affiliated with South Shore Hospital, the two Hallmark hospitals, and, if it is acquired by Partners, Emerson Hospital (which, despite being in Eastern Massachusetts, is inexplicably exempt from the Proposed Consent's prohibition against further hospital acquisitions by Partners in Eastern Massachusetts without the Attorney General's consent). This substantial increase in Partners' hospital "footprint" within Eastern Massachusetts would greatly increase its ability to add physicians to its hospital-affiliated community-based PHOs. The result is that many physician groups that the Proposed Consent purports to exclude from Partners contracts, plus groups new to the Partners Network, could be readily accommodated within the Partners contracting network through a simple change: joining a Partners hospital PHO.

These additional physicians and hospitals would substantially increase Partners' patient service revenues, and correspondingly weaken its lower-cost competitors who would lose these revenues. As Partners, like other networks, tightens its controls on referrals for population health

management and risk contracting purposes, its existing and new physicians would increasingly draw patients away from Partners' lower-cost competitors and direct them to Partners' higher-cost physicians, hospitals and other facilities, which would substantially increase total medical expenditures in Massachusetts.

The provider contracting and growth restrictions in the Proposed Consent profoundly contradict the cost-control objectives of state and federal health care reform, and would make a mockery of Massachusetts' purported leadership in these critical reform efforts. To allow this Court to make a determination that the Proposed Consent's provider growth and contracting restrictions are in the public interest, we believe the Attorney General must respond to each of the following questions:

1. Why is it in the public interest to allow the largest health system in Massachusetts, and one whose negative impact on costs has been well-documented by the Attorney General, to add three (and possible a fourth) hospital and approximately 750 to 800 physicians (not including Boston-based AMC specialist physicians for which there is no cap), which expansion is certain to add materially to already unsustainably high health care costs in Massachusetts?
2. Most of the other restrictions in the Proposed Consent range from 6.5 to 10 years in duration. Given the critical role that physicians, who refer patients to hospitals and authorize most medical expenditures, have in the health care delivery system, on what basis are the physician growth caps in place for only five years?
3. What is the public policy rationale for using January 1, 2012, the point at which we understand Partners' physician network was largest, as the baseline to determine the number of Partners' Community Physicians, thereby giving Partners the opportunity to add 750 to 800 Community Physicians over the next five years?

4. What is the public policy rationale for imposing no cap on Partners' ability to increase its number of academic specialists, in the Metro Boston area? Without such a cap, Partners could more easily increase its market power by recruiting high percentages of the physicians in key sub-specialties (e.g., transplant surgeons). As risk contracting among Payers and providers continues to grow, Partners' dominance of certain high-cost specialties could be especially damaging to the financial viability of its lower-cost competitors.
5. If the Attorney General concluded that Partners may not contract with Payers on behalf of Partners Contracting Affiliates going forward, what is the public policy rationale for allowing Partners to include the physicians associated with Contracting Affiliates in the baseline? Does doing so not reward Partners for its past anticompetitive actions?
6. On what basis are the Brigham and Women's Physicians Organization ("BWPO") physicians (other than Harbor physicians) who practice at Faulkner Hospital excluded from the Community Physician Cap, when Faulkner Hospital itself is deemed to be a Community Facility, despite its Metro Boston location? This exclusion means there would be no limit on the number of BWPO physicians that could practice at Faulkner hospital—a Community Facility—and still not be included within the Community Physician Cap. Because Partners controls Faulkner, it would seem to be a simple matter for Partners to shift any employed physician practicing in Faulkner's service area to the BWPO, especially since, as demonstrated by the proposed acquisition of Harbor, the BWPO could readily accommodate non-academic physicians.
7. What is the rationale for excluding from the definition of AMC Community Physicians (and therefore from the Community Physician Cap) AMC Physicians that provide "call coverage or temporary and non-regular health care services" to patients at facilities or offices located

outside the Metro Boston area? The number of AMC Community Physicians would be calculated regarding the number of wRVUs (a measure of clinical services) a particular AMC Physician provides in the community setting, and therefore it is unnecessary for Partners to exclude AMC Physicians providing "temporary and non-regular health care services" in the community setting. Partners could take advantage of the ambiguity in what constitutes "temporary and non-regular health care services" by taking the broadest reasonable interpretation of this phrase and excluding the community-based services of some AMC Physicians from the calculation of the number of AMC Community Physicians.

8. Partners' proposed acquisition of Emerson Hospital is not before the Attorney General or any regulatory agency in Massachusetts. Why then is Emerson Hospital proposed to be excluded from the Attorney General's automatic, required review and approval of Partners' hospital acquisitions in Eastern Massachusetts over the next seven years?
9. Why is Partners permitted to solicit physicians from non-AMC competitors like Atrius Health and from community hospital-affiliated group practices?
10. Given Partners' high profile, and widely known (through the Attorney General's cost-driver reports, press coverage, and other sources) physician rate price advantage, how effective is the limited AMC competitor non-solicitation restriction likely to be?
11. How many primary care and specialist physicians are associated with Partners Contracting Affiliates that could meet the geographic proximity requirements to join a PHO at a Partners-controlled hospital and thereby remain in Partners' contracting network? Does this exception not provide Partners with a simple workaround to the proposed exclusions from Partners' contracting network? The other clinical integration requirements would be easily met under the standard terms of any participating provider agreement.

12. Payers are unlikely to exclude Contracting Affiliates as of January 1, 2015 (or January 1, 2016 for Emerson Hospital/PHO, unless extended during the acquisition process) if the Contracting Affiliates' enhanced rates slots[67] for such Payers are simply reallocated to other Partners physicians (i.e., no net financial gain for the Payers). If Payers choose not to exclude these Contracting Affiliates, what is the public policy rationale for permitting such potentially excluded Contracting Affiliates to remain in Partners Payer Contracts for the lesser of three years or the remaining contract term?

E. Monitoring/Funding[68]

Our comments above make clear that the terms of the Proposed Consent are incomplete and ambiguous, particularly regarding the several definitions and formulas that are essential to the implementation of the price growth caps. Such incompleteness and ambiguities add significantly to the complexities of the proposed conduct remedies. Taken together, such factors would make enforcement of the terms of the Proposed Consent extremely difficult and, under its terms, resolving these difficulties would fall to this Court. Because the Proposed Consent permits Partners to determine, in the first instance, whether it violated the Proposed Consent (the Compliance Monitor's responsibility is to "verify" this determination), Partners would be likely to interpret the ambiguous and incomplete terms in the Proposed Consent in the manner that is most favorable to it. For instance, regarding the unit price growth cap formula, the Proposed Consent allows Partners to calculate the year-to-year rate of growth in prices for its commercial business using "prices in effect" during the relevant period where "prices" are not defined and such term has several possible meanings (e.g., patient "allowables" (which include co-pays and

[67] Payers typically negotiate limits on the number of Partners physicians for which Partners can bill the physicians' professional medical services at Partners highest rates (so-called "enhanced physician rate slots").
[68] *See infra* App'x § D for an explanation of the Proposed Consent's monitoring and funding provisions.

co-insurance regardless of whether they are collected), net revenue (actual prices paid less bad debt or other collection losses), carrier prices (not inclusive of patient co-pays or co-insurance) or contractual allowances (financially modeled revenue expected by provider)).

This method of determining compliance would inevitably produce disputes regarding the intended functioning of the conduct remedies that the Court must resolve during the ten-year term of the Proposed Consent. It would also put a tremendous burden on the Compliance Monitor to discover and challenge any assumptions favorable to its interests that Partners makes regarding such ambiguous and incomplete terms. Moreover, the Compliance Monitor's ability to detect Partners' adoption of such favorable assumptions successfully is partly a function of its independence and the resources available to it. The requirement that Partners agree on the Compliance Monitor's annual budgets (subject to the Attorney General's right to seek resolution of any disputes from this Court) and its right to provide input on the selection of the Compliance Monitor and its consultants raises significant concerns regarding the Compliance Monitor's independence and the adequacy of the resources available to it.

The Proposed Consent also fails to empower the Compliance Monitor with respect to key issues and creates a substantial oversight role for the Court requiring technical expertise, resources, and time in order to effectively carry out this role. For instance, the Proposed Consent requires resolution by the Court if Partners and the Attorney General cannot agree on any of the following issues: (a) whether continuing to treat physicians employed by Harbor Medical Associates as of the Effective Date as Community Physicians during the term of the Proposed Consent would be "clinically and/or administratively burdensome and impractical" for

Partners;[69] (b) whether Partners may make a Material Change to a Contracting Component;[70] (c) whether new physician groups may become a Excepted Partners Contracting Affiliates by joining a PHO of which a Partners-owned hospital is a member;[71] (d) whether Partners has satisfied all of the criteria necessary to permit the cap on growth of AMC primary care physicians to increase from 10 to 20 physicians per year for years two through five;[72] (e) whether the annual budget for the Compliance Monitor is adequate;[73] (f) whether Partners exceeded the TME Growth Cap in a particular year due to "unanticipated market conditions" such that Partners should get relief from the cap;[74] and (g) whether the data and information requested by the Compliance Monitor to verify Partners' compliance with the price growth caps is "irrelevant" to such duty.[75]

To allow this Court to make a determination that the Proposed Consent's monitoring provisions are in the public interest, we believe the Attorney General must respond to each of the following questions:

1. If the Compliance Monitor is independent of Partners:
    - Why is the Attorney General required to consult with Partners before engaging a Compliance Monitor?
    - Why is the Attorney General required to consult with Partners regarding its "arrangements" with the Compliance Monitor and any firms or persons hired by the

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[69] *Commonwealth of Massachusetts v. Partners HealthCare Sys., Inc.*, No. 14-2033-BLS, [Proposed] Final Judgment by Consent, ¶ 33 (Mass. Superior Ct. June 24, 2014), *available at* http://www.mass.gov/ago/docs/press/2014/partners-settlement-062414.pdf [hereinafter Partners Proposed Final Judgment].
[70] *Id.* ¶ 70.
[71] *Id.* ¶ 88.
[72] *Id.* ¶ 103.
[73] *Id.* ¶ 128.
[74] Partners Proposed Final Judgment, *supra* note 69, at Att. A, § IV(d)(ii).
[75] *Id.* at Att. A, § III(c)(ii), § IV(c)(iv).

Compliance Monitor?

- Why is Partners' consent required for the Compliance Monitor's annual budget (subject to the Attorney General's right to seek resolution from the Court)?
- On what bases would Partners be able to object to or to withhold its consent for any of the above items?

2. Are there any limits on Partners' obligations to fund the Compliance Monitor if the funding is not agreed to by the Attorney General and Partners but is instead determined and approved by the Court?
3. Given the many disputes in which this Court may be required to intervene if the Attorney General and Partners cannot agree, and given that judges in the Commonwealth are rotated, has the Attorney General made a request to the Regional Administrative Judge to have this matter specially assigned to Judge Sanders so she may preside over this matter for the ten-year life of the Proposed Consent? If not, will this request be made?
4. On what basis does the Attorney General believe it is in the public interest to impose these conduct remedies, which would require prolonged and intensive oversight that both diverts resources Partners could be spending to improve patient care and is likely to severely strain limited judicial resources?

IV. EXAMINING COMPONENT CONTRACTING[76]

A. Implications if Proposed Consent Implemented as Designed

1. Component contracting is a disfavored and unproven conduct remedy.

Component contracting would mean that, rather than agreeing to a single Partners network-wide agreement, Payers could choose to negotiate contracts separately with: (a) Partners' AMC providers; (b) Partners' community providers; (c) South Shore Entities; and (d) Hallmark Entities.[77] This concept is flawed in theory and doomed to fail in practice.

First, to the best of our knowledge, there is just one FTC enforcement action—in a case with "unique circumstances"—where component contracting was made available to Payers.[78] That action involved a 2008 settlement between the FTC and Evanston Northwestern Healthcare Corp. in Illinois. Despite several health care enforcement actions undertaken since the Evanston settlement, the FTC has never again agreed to component contracting as a remedy. (Moreover, but perhaps most tellingly, we understand that no Payers have ever availed themselves of the component contracting option in Illinois.[79])

Recent economic literature further supports this criticism. In a June 9, 2014 working paper by, among others, Aviv Nevo, the Deputy Assistant Attorney General for Economic Analysis and the senior-most economist in DOJ's Antitrust Division, the authors explain (using a model constructed on an abandoned hospital merger in Virginia) that a remedy creating separate

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[76] *See infra* App'x § A for an explanation of the Proposed Consent's component contracting provisions.
[77] *See infra* App'x § A(1); for information on the entities comprising these components, see *infra* App'x §§ A(2)(A)-(C).
[78] *See Opinion of the Comm'n on Remedy, In the Matter of Evanston Northwestern Healthcare Corp.*, Docket No. 9315, at 2, 9, 12 (Aug. 28, 2008), *available at* http://www.ftc.gov/enforcement/cases-proceedings/0110234/evanston-northwestern-healthcare-corporation-enh-medical-group.
[79] *See* Comment of Academic Economists In Re Commonwealth of Massachusetts v. Partners HealthCare System, Inc., South Shore Health and Educational Corp., and Hallmark Health Corp., Superior Court Civil Action No. 14-2033-BLS, at 5 (July 21, 2014), *available at* http://www.mass.gov/ago/docs/partners/academic-economists.pdf.

bargaining units as proposed here, would have done nothing to alleviate price increases resulting from that consolidation.[80] While the facts the authors used to arrive at that conclusion differ from those facts before us, the analysis remains instructive for this Court because it suggests component contracting is not an effective remedy for otherwise anticompetitive mergers.

Component contracting is further doomed to fail because it ignores how provider-payer contracting actually works in Massachusetts. To the best of our knowledge based on discussions with market participants, no Payers who were offered the opportunity to engage in component contracting in the *FTC v. Evanston* matter have ever chosen to do so. Instead, Payers doing business in that market continue to negotiate network-wide contracts. Similarly here, there is no reason to expect that Payers would want to negotiate on a component basis. Limited network insurance products have not been attractive to employers and patients in Massachusetts, so it is highly unlikely Payers would be willing to leave a Partners component out of its network, due to likely employer and patient resistance. Partners knows of this likely resistance, and that, accordingly, Payers would be unwilling to exclude its components from their networks. Therefore, simply dividing Partners into components would not be likely to provide Payers with the leverage they need to negotiate lower rates for Partners providers.

Even if component contracting were theoretically able to bring about price reductions (which, again, recent economic literature disputes), practically speaking, negotiating multiple contracts with the same health care system would be more burdensome and time consuming than

[80] Article by Gautam Gowrisankaran (University of Arizona, HEC Montreal and NBER), Aviv Nevo (Northwestern University and NBER), and Robert Town (University of Pennsylvania and NBER), *Mergers When Prices are Negotiated: Evidence from the Hospital Industry* (June 9, 2014), forthcoming American Economic Review. Aviv Nevo's biography is available at http://www.justice.gov/atr/about/daag.html.

the current methods which are already excessively burdensome and time consuming.[81] The typical major Payer contract takes a minimum of six to 12 months to negotiate—and longer if it is a new form of contract or an otherwise new arrangement. We expect, based upon our experiences, that Partners includes a minimum of five people on a typical negotiating team; at 30 to 40 hours of negotiating multiplied by five people, that is 300 to 400 hours per contract for just one contracting party. Breaking the contracting process down into components would compound these numbers, and contribute to increasing health care costs. Component contracting has also never been attempted in the Eastern Massachusetts health care market. Put simply, the Proposed Consent would ask the Payers to participate in an experiment and make unprecedented changes to their contracting processes resulting in increased administrative costs with no guaranteed, or even likely, upside in terms of reduced costs.

Component contracting would also require extensive oversight by the Attorney General and the Compliance Monitor. Such oversight would add layer upon layer of inefficiency to an already challenging negotiating process and would lead to inevitable delays in reaching agreement between Partners and the Payers.

Finally, component contracting would do nothing to affect the physician referral patterns which underpin Partners' current monopoly advantage. Specifically, component contracting is an incomplete response to a market failure in that it would do nothing to prevent Partners from rewarding physicians, including employed physicians and otherwise independent physicians participating in its Payer contracting network, for keeping referrals within the network. (For

[81] Some commenters have asked whether separate negotiating teams would need to be created for each component. For example, it could raise anticompetitive information sharing concerns if an individual at a payer negotiating with Partners' Academic Medical Centers would also be the individual negotiating with South Shore Hospital. That individual would be privy to the AMC rates and the South Shore Hospital rates which would undo any hope of creating competition among between those components.

example, Partners' electronic medical records system makes "one-click" in network—but not out of network—referrals simple and efficient.) Partners' provider components may contract separately but, in the end, all Partners providers—both those currently in the network and those that may be added under the Proposed Consent—would still be controlled by Partners, changing nothing about the contracting status quo that has so well served Partners' financial interests and harmed those of the citizens of Massachusetts over the past 20 years.

V. EXAMINING THE PRICE GROWTH RESTRICTIONS[82]

A. Implications if Proposed Consent Implemented as Designed

1. In General

a) Neither patients nor other Risk Providers are guaranteed any relief under the price growth caps.

The Proposed Consent provides that any refunds of overpayments Partners makes during the price growth cap term are "for the benefit of the market and . . . should be reflected in the cost to the consumers of the Health Insurance Products to which such refunds are applicable."[83] Because the Payers are not parties to the Proposed Consent, such language is aspirational on the part of the Attorney General and highlights a recognition by the Attorney General that the sole remedy for Partners' violations of the price growth caps benefits only the Payers with no corresponding obligation on the Payers to pass these benefits along to either: (i) the patients who paid higher health insurance premiums (as well as higher co-pays and deductibles) when they used Partners' providers; or (ii) the provider risk entities who similarly bore the higher prices under their risk arrangements.

2. Unit Price Growth Cap[84]

a) Setting the unit price growth cap at the lower of general inflation or medical inflation would preserve Partners' market-power-derived price advantage in its commercial business relative to other providers.

While Partners' prices in its commercial business may have historically increased at a rate higher than general inflation (so the Proposed Consent would cause lower rates of increase), the efficacy of the unit price growth cap must be examined in a context in which the prices for the commercial business of almost all of Partners' competitors have historically increased at a

[82] *See infra* App'x § B for an explanation of the Proposed Consent's price growth restrictions.
[83] Partners Proposed Final Judgment, *supra* note 69, at Att. A, § III(d)(i)(3) & § IV(d)(i)(4).
[84] *See infra* App'x § B(1) for an explanation of the Proposed Consent's unit price growth restriction.

rate lower than that obtained by Partners. This is, not surprisingly, due primarily to the difference in market power between Partners and these other providers. Therefore, under the Proposed Consent, Partners' prices, which are already much higher than those of other providers, would be likely to continue growing at a faster rate than those of the other providers (even if that rate is lower than its historical rate) because Partners would still be able to use its market power to obtain the highest available rate increases and the Payers, in an effort to control medical expenditures and health insurance premium costs, would likely offer lower rate increases to other providers, as they do now.

This trend would exacerbate the current, severe distortions in the market to which the Attorney General has drawn attention in her influential cost-driver reports.[85] (Those reports also conclude that Partners' higher prices are not explained by differences in the quality or complexity of care delivered, or other any other value-based factors).[86] Partners would continue to use its market power to extract from the Payers supra-competitive price increases (i.e., to be the only provider who obtains annual price increases at the level of general or medical inflation). Patients in Eastern Massachusetts would ultimately pay for such price increases in the form of increased health insurance premiums and, as employers continue to respond to these increases by cost-shifting to their employees, increased shares of such premiums as well as higher co-pays and deductibles.

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[85] *See, e.g.*, 2013 COST DRIVERS REPORT, *supra* note 3, at 34 (noting discrepancies in TME across the Commonwealth, and noting the Partners maintains the highest TME in four out of the five regions of the Commonwealth measured).
[86] *See id.* at 19.

b) The unit price growth formula could enable Partners to obtain effective price increases on services greater than the rate of inflation.

The Proposed Consent's unit price growth cap formula: (a) compares the total payments made by Payers to Partners for all services provided by Partners in a particular baseline year (equal to the sum of baseline year services multiplied by baseline year prices) against the theoretical total payments that would cause the next "measurement" year if Partners provided the exact same set of services provided in the baseline year re-priced at the prices charged by Partners for such services in such following year; and (b) restricts the rate of growth in such payments (and therefore price growth) to the lower of general inflation or medical inflation.[87] The Proposed Consent also contemplates that Partners could negotiate different price increases for different services from year to year. If this occurs, the Proposed Consent makes clear that in order to calculate the rate of growth from baseline year payments to measurement year payments, the different price changes in services must be weighted by the proportion of payments for such services in the baseline year relative to total payments for all services in the baseline year.[88]

The unit price growth cap formula is inherently flawed because it enables Partners to: (a) use its market power to obtain a price increase for a particular measurement year in excess of inflation regarding a particular service (e.g., outpatient cardiac care) for which Partners forecasts there would be increased demand (and therefore increased volume) in such measurement year; (b) offset that price increase with a price decrease (or lower increase) for a service for which Partners forecasts there would be decreased demand (and therefore decreased volume) in the measurement year, such that the price increase across all services (weighted based on baseline

[87] *See infra* App'x § B(1)(2).
[88] *See* Partners Proposed Final Judgment, *supra* note 69, at Att. A, § III(a)(viii).

payments, and therefore the baseline year volume, for such services) does not exceed inflation; and (c) achieve an effective price increase across all services (weighted based on actual measurement year payments, and therefore the measurement year volume, for such services) greater than inflation.[89] A numerical example of this flaw is attached as Exhibit A.

Partners would not have to modify its current contracting practices to take advantage of the flaw described above. This is because Partners, like all providers, already negotiates Payer contracts with differential pricing based on particular services and products and Partners, like all providers, has good information regarding which services and products are increasing and decreasing on a relative volume basis.

c) The unit price growth cap formula as described in the Proposed Consent places no restrictions on Partners' ability to charge supra-competitive prices for services that did not exist in the baseline year, and to lock in those price increases for future years during the unit price growth cap term.

The unit price growth cap formula only restricts prices charged in a particular measurement year regarding a set of services that Partners provided in the preceding baseline year.[90] The unit price growth cap formula does not include explicit adjustments if Partners provides a new service in the measurement year or ceases to provide a service in the measurement year. If Partners provides a new service in the measurement year, it could use its market power to obtain an unrestricted, supra-competitive price for such service. This is because the new service would first appear in the unit price growth cap calculation in the *second* year it is offered as part of the baseline set of services provided in the *baseline year*. The supra-

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[89] This could include rate increases to: "(1) service categories that are popular or expanding (for Partners, the state's largest tertiary referral system, this includes a spectrum of high-margin specialty services), (2) popular providers to which consumers are least price-sensitive, and (3) Partners providers who are not as dominant or profitable in their areas as Partners' most well-established providers, potentially to optimize the market position of these providers at the expiration of the settlement." HPC PARTNERS-HALLMARK FINAL REPORT, *supra* note 6, Ex. B at 3.

[90] *See infra* App'x § B(1)(2).

competitive price for such service would therefore be locked into all of the succeeding unit price growth cap calculations.

If Partners ceases to provide a particular service in the measurement year, the Proposed Consent contains no explicit requirement to adjust the baseline year payments to remove the revenue associated with such service, and therefore the measurement year payments would be artificially low causing the price increase derived from the unit price growth cap formula to be artificially low.

d) Failing to apply the unit price growth cap separately to the Hallmark providers would permanently increase total medical spending in northeastern Massachusetts.

As noted in HPC's preliminary cost and market impact review concerning Partners' proposed acquisition of the Hallmark Entities, by failing to apply the unit price growth cap separately to the Hallmark providers, Partners would be expected to increase the prices charged by such providers significantly faster than the rate of inflation, and to offset the impact of that price increase, for purposes of the unit price growth cap, with lower increases across the remainder of its system. The HPC anticipates that such price increases would set a new, permanent baseline upon which future price increases for the Hallmark providers would be negotiated, including prices negotiated after the 6.5-year unit price growth cap term, and would permanently increase total medical spending in northeastern Massachusetts.[91]

[91] The HPC's cost and market impact review concerning Partners' acquisition of Hallmark Health System was published after filing of the Proposed Consent and specifically examines the efficacy of the unit price growth cap as presented in the Proposed Consent in reducing health care cost growth. *See* HPC PARTNERS-HALLMARK FINAL REPORT, *supra* note 6, at 43–44.

e) The Proposed Consent does not prevent Partners from operating its Neighborhood Health Plan HMO in a manner that would increase total health care spending.

We appreciate the reasons for excluding Partners'-controlled Neighborhood Health Plan ("NHP") HMO from the price growth cap formulas (e.g., not permitting the rate of growth in Partners' prices charged to NHP to affect the price growth cap formulas). However, the Proposed Consent does not go far enough to prevent Partners from cross-leveraging its payer and provider roles in a manner that could increase total health care spending. For example, Partners could shift the market toward NHP's health insurance products (e.g., by moving all of their employees and their families to NHP) and, subject to applicable health insurance regulations, boost the margin of NHP by providing services to NHP at lower prices than provided to other Payers, which would put pressure on other providers to provide services to NHP at similarly low prices. This problem would be exacerbated if NHP's further expands its operations as a third party administrator for self-funded employers or as an underwriter on commercial insurance products. The potential shift in dollars from Partners as a provider to Partners as an insurer could further eviscerate the price growth cap formulas. Such problems recently caused serious upset within Pittsburgh's health care market, where a high-profile and lengthy dispute between the University of Pittsburgh Medical Center ("UPMC") and Highmark Inc. over similar contracting issues has required serious intervention by both the Governor and the Attorney General.[92]

[92] *See, e.g.*, *Details of UPMC, Highmark Split Made Public*, WTAE PITTSBURGH ACTION NEWS 4 (Jun. 27, 2014, 10:14 PM), *available at* http://www.wtae.com/news/live-video-governor-corbett-attorney-general-kane-to-comment-on-highmark-and-upmc-agreement/26692536#!bGHEQh.

3. TME Growth Cap[93]

a) Setting the TME Growth Cap at the HPC Cost Growth Benchmark would widen the gap of resources available to care for Partners patients relative to non-Partners patients.

The Massachusetts Center for Health Information and Analysis ("CHIA") has found that just "[f]our of the largest managing physician groups were associated with HSA TME [Health Status Adjusted Total Medical Expenses][94] above the 3.6% benchmark in any of the three major payers' networks."[95] And, further, that Partners "was the only physician group that was both higher than the network average and had an increasing HSA TME across all three major Massachusetts payers between 2012 and 2013."[96] These TME measures are expressed on a per member per month basis ("PMPM").[97] Partners receives higher PMPM payments because it exercises its market power to obtain supra-competitive prices for health care services (prices which, the Attorney General has concluded, are not adequately explained by differences in the quality or complexity of care delivered by Partners, or other value-based factors).

As a result of such higher PMPM payments, Partners receives more funds from Payers to provide care to its patients relative to patients of other providers under risk contracts. Under the TME Growth Cap formula, the annual rate of increase in Partners' PMPM payments is capped at the level of the HPC Cost Growth Benchmark (3.6 percent for 2014).[98] If the PMPM payments

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[93] *See infra* App'x § B(2) for an explanation of the Proposed Consent's TME growth cap.
[94] The HSA TME metric "accounts for variations in health status of a payer's full-claim members," and "allows for a more refined comparison of TME trends between payers." CHIA 2014 REPORT, *supra* note 2, at 14. "Full-claim members" are members for whom the payer directly covers and reports to CHIA all components of TME, including self-insured plans. *Id.* at 14 n.28.
[95] *Id.* at 14. In previous years, CHIA has similarly found that Partners' TME is at or near the highest level for each of the three major Payers in Massachusetts. COMMONWEALTH OF MASSACHUSETTS, CENTER FOR HEALTH INFORMATION AND ANALYSIS, ANNUAL REPORT ON THE MASSACHUSETTS HEALTH CARE MARKET, Figure 25 (August 2013), *available at* http://www.mass.gov/chia/docs/r/pubs/13/ar-ma-health-care-market-2013.pdf.
[96] CHIA 2014 REPORT, *supra* note 2, at 14.
[97] *Id.* at 23.
[98] The cost growth benchmarks are established by MASS. GEN. LAWS ch. 6D, § 9(b) (2012).

received by Partners and other providers grows from year to year at the level of the HPC Cost Growth Benchmark, then the resource gap between Partners and other providers noted above would continue to widen to the detriment of non-Partners' patients.

Furthermore, there is considerable ambiguity surrounding how TME growth will be monitored and whether any monitoring could be effective. For example, and similar to the issues regarding the baseline in the unit price growth cap, the Proposed Consent measures Partners' TME growth in the aggregate. The baseline TME, however, could vary significantly from the performance year TME, and some important factors are unaccounted for in the Proposed Consent. For instance, fiscal year 2014 does not appear to be adjusted for the Hallmark Entities, meaning that when the Hallmark Entities join Partners, Partners would, overall, experience a "decrease" in TME simply by virtue of the Hallmark Entities' lower cost base. This advantage would continue over the following two to three years given the Cumulative Weighted TME. Other factors that may similarly skew the growth measurement include a change in Payer mix or in mix of plan products and carve outs from risk.

Additionally, the TME for the TME Measurement Period would include any contractual surpluses or deficits. Savings that Partners creates due to their planned efficiencies (as noted in their defense of the proposed South Shore and Hallmark acquisitions) that relate and accrue back to Risk Arrangements would decrease TME and accrue to Partners as surplus. As long as any surpluses stay within the growth cap when added to baseline expenses, Partners would be able to keep the surplus under their Payer Risk Arrangements. This outcome would reduce the benefits that would accrue to the market (i.e., consumers) under the Proposed Consent.

VI. EXAMINING THE PROVIDER CONTRACTING AND PHYSICIAN GROWTH RESTRICTIONS[99]

A. Implications if Proposed Consent Implemented as Designed

1. In General

In both its final report regarding Partners' proposed acquisition of the South Shore Entities dated February 19, 2014 and regarding Partners' proposed acquisition of the Hallmark Entities dated July 2, 2014, the HPC found that the proposed transactions would increase health care spending in Eastern Massachusetts, increase Partners' market power and reduce market competition in this region, and increase premiums for employers and consumers.[100] Specifically, the HPC found that the proposed transactions with the South Shore Entities and the Hallmark Entities would increase total medical spending in Eastern Massachusetts primarily due to: (a) Partners' ability to obtain higher prices and other favorable contract terms in negotiations with commercial Payers stemming from increased market concentration of inpatient and physician services in the northeastern Massachusetts and South Shore regions; (b) increase physician, hospital, and other facility unit prices stemming from further consolidation or alignment of newly-owned providers (e.g., South Shore PHO (including Harbor) physicians and Hallmark physicians moving to higher "integrated" PCHI rates); and (c) increased utilization of Partners' higher-priced facilities and physicians and resulting decreased utilization of lower-cost competitors stemming from changes in referral patterns of newly-affiliated physician groups.[101]

The Attorney General believes that the price growth cap described in Section V sufficiently addresses the unit price concerns raised by HPC. We describe in Section V why the

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[99] *See infra* App'x § C for an explanation of the Proposed Consent's provider contracting and physician growth restrictions.

[100] *See* HPC PARTNERS-SOUTH SHORE FINAL REPORT, *supra* note 6, at 2; HPC PARTNERS-HALLMARK FINAL REPORT, *supra* note 6, at 3 ("This transaction is projected to reinforce Partners' market power and increase medical spending in northeastern Massachusetts, notwithstanding the proposed settlement.").

[101] *See* HPC PARTNERS-SOUTH SHORE FINAL REPORT, *supra* note 6, at 29–45.

price growth caps would be ineffective during the limited period in which they apply (and would do nothing to control Partners' behavior after expiration of such period). It is important to emphasize, however, that the Attorney General's proposed price growth caps and other conduct remedies (e.g., component contracting) do nothing to address increased total medical spending resulting from changes in referral patterns as newly-affiliated physicians shift utilization to Partners' higher-priced providers and away from lower-cost competitors. The TME Growth Cap is wholly insufficient to address this negative impact highlighted by the HPC in its cost and market impact reviews, because the TME Growth Cap covers only Partners' risk business, which accounts for only 11 percent of Partners' total commercial business.[102]

As the HPC notes, over time the increased spending baseline from such site-of-care effects would impact consumers and Payers in the affected regions, as well as providers who refer their patients to South Shore Hospital and Hallmark facilities and physicians and are increasingly at risk for such patients' total medical spending.[103] As Partners continues to acquire additional hospitals and grow its community physician network, as authorized by the Proposed Consent, the cost impacts on patients in terms of higher health insurance premiums, deductibles, and co-pays resulting from shifting care to higher-cost settings would increase significantly over time.

2. Restrictions on Affiliate Contracting

Subject to the Community Physician Cap, Partners would be permitted to convert potentially excluded physician groups into, and add new physician groups as, excepted groups by arranging for those physician groups to participate in Partners' Payer Contracts through a Partners-owned hospital PHO (i.e., simply by having such groups join a Partners owned-hospital

[102] *See* HPC Public Comments, *supra* note 7, at 4.
[103] *See* HPC PARTNERS-SOUTH SHORE FINAL REPORT, *supra* note 6, at 2.

PHO).[104] The barriers to such conversion are low. The minimal standard for clinical integration set forth in the Proposed Consent is a standard that is met, and often exceeded, by PCHI and all other contracting networks based on the practical reality that this type of integration is necessary to perform effectively under the pay-for-performance and other risk features of modern Payer contracts. In addition, the Proposed Consent does nothing to address financial penalties in existing contracts between Partners and excluded physician groups that could be triggered if such groups left the Partners contracting network. Such penalties may force excluded groups to convert to excepted groups under the terms of the Proposed Consent by joining a Partners-owned hospital PHO.

To the extent potentially excluded physician groups were affiliated with Partners on January 1, 2012, the number of participating physicians in such groups on that date would be included in Partners' Baseline Community Physician Cap. Therefore, as Partners converts loosely-controlled affiliates into more tightly-integrated affiliates, Partners' market power would increase even without increasing the total numbers of physicians participating in Partners' physician network. Referrals from such converted physician groups would become more tightly controlled and managed, which would reduce patient leakage from these groups and increase Partners' patient volume at its higher rates, and accordingly decrease patient volume at Partners' lower-cost competitors, with a resulting increase in total health care costs in Massachusetts.

3. Restrictions on Partners' Physician Growth in Eastern Massachusetts

a) Community Physician Cap[105]

As of the Effective Date, Partners would have about 2,170 Community Physicians (including AMC Community Physicians), and a Community Physician Cap of 2,770 during years

[104] *See infra* App'x § C(1)(4).
[105] *See infra* App'x § C(2)(a).

1-3, and approximately 2,825 in year 4, and 2,880 in year 5. Approximately 400 Community Physicians would join Partners from South Shore PHO (including the Harbor physicians) as a result of the South Shore transaction, leaving approximately 200 open Community Physician slots during years one through five, plus approximately 110 additional physicians in years four and five. After year five, there would be no limit on Partners' physician growth other than through general enforcement of the antitrust laws, which has historically been ineffective in controlling Partners' growth.

There are several pathways by which Partners could create or otherwise have additional Community Physician slots during the term of the Community Physician Cap. First, to the extent non-owned physician groups that participated in Partners Payer Contracts as of January 1, 2012 could not join a Partners-owned hospital PHO after the Effective Date (e.g., Charles River Medical Associates), then the departure of these groups would free up additional Community Physician slots that Partners could fill. Second, Partners could create additional Community Physician slots by moving the practice sites of AMC Community Physicians from Community Facilities to AMC facilities as well as by moving BWPO physicians to Faulkner Hospital, which physicians, though working at what is deemed to be a Community Facility, would still not be counted against the Community Physician Cap.

Third, Partners could move AMC physicians to AMC facilities in the Metro Boston area, which would reduce the aggregate wRVUs performed by AMC physicians in the community setting, and thereby directly increase slots for Community Physicians participating in Payer contracting through entities other than BWPO or MGPO. Fourth, Partners could create additional Community Physician slots by convincing the Attorney General (or the Court, if the Attorney General does not agree) that it would be "clinically and/or administratively burdensome

and impractical" to continue to classify Harbor physicians as Community Physicians if such physicians were transferred from BWPO to another Partners-owned AMC provider (e.g., MGPO).

The PHO exception to the joint contracting prohibition and the room under the Community Physician Cap available on the Effective Date of the Proposed Consent (approximately 600 slots) would enable Partners to use its rate advantage and other resources to quickly absorb the approximately 400 South Shore PHO physicians (including the Harbor physicians), plus at least 200 additional physicians during years one through five , plus approximately 110 additional Community Physicians in years four and five. The Proposed Consent therefore would permit the Partners community physician network, already the largest in the state, to grow by 28 percent over three years and 33 percent over five years (including immediate growth of 18 percent upon closing of the South Shore transaction).

Partners would be able to use any available enhanced physician rate slots in its Payer Contracts to bill the professional services of some of the newly-affiliated physicians at higher rates.[106] To the extent that Partners Payer contracts do not currently have available enhanced rate slots, and, therefore, certain Community Physicians would receive only standard, state-wide rates from Payers, this would mitigate the short-term cost impacts associated with this dramatic growth in the Partners community physician network. However, over time, Partners could be expected to use its increased leverage to obtain more such enhanced rate slots from Payers or to effectively eliminate such restriction, and to further benefit from the enhanced or eliminated rate slot system by moving physicians from one category to another (e.g., labelling some of its

[106] Payers typically negotiate limits on the numbers of Partners physicians for which Partners can bill the physicians' professional medical services at Partners highest rates (so-called "enhanced physician rate slots").

academic physicians as "scientists," primarily researchers rather than clinicians, and then using the freed-up enhanced rate slots for active, full-time practicing physicians).

More importantly, regardless of whether the newly-affiliated Partners physicians would enjoy the top-of-market rates for physician services (and there is every reason to think that a larger and growing portion of them would do so), all of the physicians added to Partners' physician network would increase their referrals to Partners' higher-cost specialist physicians, hospitals, and other facilities and away from Partners' lower-cost competitors. The associated incremental patient volume shifts would significantly increase the cost of health care in Eastern Massachusetts, to which Payers would respond by increasing patients' health insurance premiums, and to which employers would respond by cost-shifting to employees/patients in the form of depressed wages, larger shares of the increased health insurance premiums and increased co-pays and deductibles, which is exactly what has happened in the past.

b) AMC PCP Cap[107]

Under the Proposed Consent, there would be no limit on Partners' ability to add primary care, family practice, or pediatric medicine physicians that: (a) are employed by, leased to, a member of, affiliated with, or participate for Payer contracting through BWH, BWPO, MGH or MGPO; and (b) have a panel[108] size below the relevant thresholds, other than the extent to which these physicians could practice in the community setting (if the Community Physician Cap is reached). Additionally, there is no explanation of or basis for the thresholds established in the Proposed Consent, and it is unclear why there needs to be—or even should be—any thresholds at all for the AMC PCPs. They appear entirely arbitrary and to only give Partners yet another opportunity to manipulate the Proposed Consent.

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[107] *See infra* App'x § C(2)(b).

[108] Note there is no standard industry definition for "panel," and the Proposed Consent does not define this term.

c) Other Restrictions and Terms Relating to Physician Growth[109]

(1) No cap on AMC specialist physicians practicing in Metro Boston area.

Under the Proposed Consent, there would be no cap on AMC specialist physicians practicing in Metro Boston area. Specifically, there would be no limit on Partners' ability to add physicians in specialties other than primary care, family practice, or pediatric medicine who are employed by, leased to, a member of, affiliated with, or participate for Payer contracting through BWH, BWPO, MGH, or MGPO, other than the extent to which these physicians practice in the community setting (if the Community Physician Cap is reached). This means there would be no caps on Partners' ability to corner the market on high-cost specialty services in Metro Boston AMC settings—and it incentivizes Partners to send patients to Metro Boston AMCs for this higher cost specialty care.

(2) No cap on advanced practice nurses or physician assistants.

Under the Proposed Consent, there would also be no cap on the number of advanced practice nurses or physician assistants that Partners could add to its network of health care professionals. Adding advanced practice nurses and physician assistants to primary care practices can cause significant increases in the panel size of such practices. Furthermore, nurse practitioners and physicians assistants can serve as primary care providers with their own panels under Massachusetts law. Partners can therefore take advantage of this gap in the Proposed Consent to increase primary care panel sizes in a meaningful way, which would have the similar effects on health care costs as adding new primary care physicians to the Partners' physician network.

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[109] *See infra* App'x § C(2)(c).

(3) The AMC non-solicitation provision would be ineffective in curtailing Partners' physician recruitment efforts.

The AMC non-solicitation provision, which is limited to competitor AMCs, would not be effective in curtailing Partners' physician recruitment efforts because Partners' rate advantage, reputation, and resources are widely known among the Massachusetts physician community. Any physician at all inclined to join Partners would know how to do so, especially since those physicians would now know that Partners is prohibited from "making the first call."

4. Restrictions on Partners' Hospital Growth in Eastern Massachusetts[110]

Partners could use its rate advantage and other resources to continue to acquire facilities, other than hospitals (e.g., Ambulatory Surgery Centers, imaging centers, home health agencies, long term care facilities, ambulance companies, etc.), in service lines for which Partners has market power. In addition, Partners has no limits on growth within NHP.

"Acquisition" of hospitals is not defined. Without such a definition, Partners could lease or manage a hospital, obtain substantial control over a hospital's governing body, or undertake other transactions designed to give Partners effective control of a hospital during the prohibition period. In addition, the limitation to acquisitions would appear to place no limits on Partners' ability to "affiliate" (not for Payer contracting purposes) with hospitals in a manner designed to control or otherwise influence the flow of tertiary and quaternary referrals to Partners' AMC hospitals. Partners has already demonstrated its ability to do this, with, for example, Dana-Farber/Brigham and Women's Cancer Center, the Dana-Farber/Brigham and Women's Cancer Center at Milford Regional Medical Center, and the Dana-Farber/Brigham and Women's Cancer Center in clinical affiliation with South Shore Hospital.

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[110] *See infra* App'x § C(3).

VII. CONCLUSION

As demonstrated, the Proposed Consent wholly fails to address the underlying problem of Partners' monopoly power and, as such, is incapable of preventing the vast anticompetitive effects that would inevitably derive from the proposed acquisitions. Approving the Proposed Consent as proposed would leave the Commonwealth—including patients, employers, Payers, and risk-bearing provider networks—subject to further significant abuse and price exploitation by Partners. Accordingly, we respectfully request the Court seek further explanation from the Attorney General regarding how these terms were reached and why she believes they will be effective, and reject the Proposed Consent if the Attorney General does not provide satisfactory answers.

Respectfully submitted,

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September 11, 2014

APPENDIX: SUMMARY OF THE PROPOSED CONSENT

This section includes summaries of each of the remedies proposed in the Proposed Consent (component contracting, price growth restrictions, and provider contracting and growth restrictions), as well as the mechanics regarding the Compliance Monitor. To assist the Court in its determination of whether the Proposed Consent is in the public interest, these summaries provide a high-level overview of the terms but not an exhaustive description of every provision of the Proposed Consent.

A. Component Contracting

1. For seven years from the Effective Date, Partners shall permit each Payer, at the Payer's option, to negotiate Payer Contracts separately with one or more of the AMC Contracting Component, Community Contracting Component, South Shore Contracting Component, or Hallmark Health Contracting Component (Secs. 64-65).
2. For years eight through ten after the Effective Date, Partners shall permit each Payer, at the Payer's option, to negotiate Payer Contracts separately with the AMC Contracting Component and the Community Contracting Component (which shall include the entities comprising the South Shore Contracting Component and the Hallmark Health Contracting Component) (Secs. 64, 66).
    A. The AMC Contracting Component means, collectively, BWH, BWPO, MGH, MGPO, McLean Hospital, Spaulding Rehab. Hospital, Spaulding Hospital – Cambridge, Spaulding Nursing and Therapy Centers North End and West Roxbury, all other facilities listed on the DPH/DMH license of any such Partners-owned provider, and all physicians that participate in any such Partners-owned provider for Payer contracting (except Harbor physicians participating in BWPO for Payer contracting) (Sec. 3).

B. The South Shore Contracting Component means, collectively, South Shore Health and Educational Corporation, South Shore Hospital (including all facilities listed on the hospital license issued by DPH), South Shore PHO, Harbor Medical Associates (whether or not Harbor and/or the Harbor physicians participate in South Shore PHO for Payer contracting), all other entities that become corporate affiliates of SSHEC and/or SSH, and all physicians that participate in a SSHEC and/or SSH corporate affiliate for Payer contracting (Sec. 53).

C. The Hallmark Health Contracting Component means, collectively, Hallmark Health Corporation, Hallmark Health System (including the Melrose-Wakefield Hospital campus and the Lawrence Memorial Hospital campus, and all other facilities operated by HHS on the hospital license issued by DPH), Hallmark Health Medical Associates, Hallmark Health PHO, all other entities that become corporate affiliates of HHC and/or HHS, and all physicians that participate in a HHC and/or HHS corporate affiliate for Payer contracting (Sec. 30).

D. The Community Contracting Component (for years 1-7) means, collectively, all of the Partners providers other than the Partners providers that comprise the AMC Contracting Component, South Shore Contracting Component, and Hallmark Health Contracting Component (Sec. 13).

(1) Effective June 1, 2018, Partners may elect to treat Cooley Dickinson Hospital, and its affiliated entities, as a separate contracting component, or to add such entities to the Community Contracting Component (Sec. 110).

3. If during the first year, a Payer re-opens an existing Partners Payer Contract to exercise its component contracting options, any new Payer Contract would not take effect until January 1, 2015 (Sec. 71).
4. By January 1, 2015, Partners would need to make any necessary changes its network affiliation and participation agreements with Contracting Affiliates to require participation in all Payer Contracts entered into by the respective Contracting Component as a condition of participation in the Partners Network (Sec. 72).
5. Partners must obtain the consent of the Attorney General (or the Court, if the Attorney General refuses to consent) to: (a) close all or substantially all of the operations or facilities of any Partners provider; (b) merge a Partners provider or Partners owned-hospital PHO that is part of Contracting Component into a Partners provider or Partners owned-hospital PHO, respectively, that is part of another Contracting Component; (c) transfer DPH licensure of a facility from a provider that is part of one Contracting Component to a provider that is part of another Contracting Component (Sec. 70).

B. Price Growth Restrictions

1. Unit Price Growth Cap

1. Term and Scope
   A. The Unit Price Growth Cap ("UPGC") would be in place for 6.5 years, beginning October 1, 2014 (Att. A, Sec. I(b)(i)).
   B. The UPGC would apply to Partners' Commercial Business, including its Commercial Risk Business (Att. A, Sec. I(d)).
      (1) Partners' Commercial Business means the commercial business from all Payer Contracts entered into by Partners with Payers on behalf of some or all of Partners-

owned providers or Partners Contracting Affiliates across all of such Payers' products (Att. A, Sec. I(d)(ii)).

a. But does not include Payer Contacts with Partners-controlled Neighborhood Health Plan (Att. A, Sec. I(d)(i)).

(2) Partners' Commercial Risk Business means Partners' Commercial Business for which Partners bears substantial financial risk (at least five percent of payments) associated with Total Medical Expense for a population of patients under a Payer Contract (Att. A, Sec. I(d)(iii)).

C. The UPGC would apply separately to the AMC Contracting Component, Community Contracting Component (which, for purposes of the UPGC, includes the Hallmark entities), and the South Shore Contracting Component (Att. A, Sec. I(e)(i)).

2. General UPGC Price Growth Restriction: For each fiscal year (or part thereof) from October 1, 2014 through March 31, 2021, the weighted average Relative Price Increase across all Payers shall not exceed the UPGC (Att. A, Sec. III(c)).

A. The Relative Price Increase for a Payer for a particular fiscal year (each a "Measurement Period") would be equal to the percent change between: (a) the total payment ("Baseline Payment") in the immediately preceding fiscal year (the "Baseline Period") by the Payer to all Partners providers for the set of services provided by such Partners providers to the Payer in such Baseline Period (the "Baseline Set of Services"); and (b) the theoretical total payment that would have been made by the Payer to all Partners providers for the Baseline Set of Services at the then-current Payer Contract rates (the "Measurement Period Payment") (Att. A, Sec. III(a)(vii)).

(1) Exception: If the Payer Contract with the Payer specifies a percent price change that applies to all services provided by Partners providers, the Relative Price Increase equals that contractually specified price change (Att. A, Sec. III(a)(vii)).

(2) For any newly-acquired providers (e.g., South Shore entities, physician groups with 10 or more physicians), the Baseline Payments applicable to the new provider would be all payments to the provider in the fiscal year prior to their joining the Partners Network as valued at their rates and service volumes in place prior to joining the Partners Network (Att. A, Sec. III(c)(iii)(2)).

B. The average Relative Price Increase across all Payers would be weighted by each Payer's Baseline Payments as a proportion of all Payers' Baseline Payments (Att. A, Sec. III(a)(viii)).

C. The UPGC is the lower of the percent change in the: (a) General Inflation Index; or (b) the Medical Inflation Index for each Measurement Period (Att. A, Sec. III(b)).

3. Remedy if the weighted Relative Price Increase across all Payers is above the UPGC in a particular Measurement Period.

A. Partners would calculate the amount by which the total Measurement Period Payments less total Baseline Payments exceeded the permissible increase dictated by the UPGC (Att. A, Sec. III(d)(i)).

B. Partners would allocate this aggregate amount to the Payers whose Relative Price Increase exceeded the UPGC (Att. A, Sec. III(d)(i)).

C. The Payer would have the option of receiving the overpayment in the form of a cash settlement, future rate adjustment, or other mutually agreeable terms (Att. A, Sec. III(d)(i)(2)).

D. The prices used to calculate the Baseline Payments by such Payer for the Relative Price Increase calculation for the next Measurement Period would be adjusted downward to reflect this return of any overpayment (Att. A, Sec. III(d)(ii)).

4. Process

A. For each Measurement Period, Partners would provide to the Compliance Monitor: (a) the weighted Relative Price Increase across all Payers for each of the three Contracting Components; and (b) the calculation of the UPGC within 15 days of the date on which the General Inflation Index and Medical Inflation Index for September in each Measurement Period (or March for the final period) are published by the Bureau of Labor Statistics (Att. A, Sec. III(b)(iii)–(c)(i)).

B. Partners would provide all information or data the Compliance Monitor requests to verify whether the weighted Relative Price Increase across all Payers exceeds the UPGC for each of the three Contracting Components (Att. A, Sec. III(c)(ii)).

(1) If Partners believes the Compliance Monitor is requesting irrelevant information or data, it could seek relief from the Attorney General (or the Court, if the Attorney General does not agree) (Att. A, Sec. III(c)(ii)).

2. TME Growth Cap

1. Term and Scope

A. The TME Growth Cap would be in place for 6.5 years, beginning January 1, 2015 (Att. A, Sec. I(b)(ii)).

B. The TME Growth Cap would apply to Partners' Commercial Risk Business (as defined above) (Att. A, Sec. I(d)).

2. General TME Growth Cap Restriction: For each calendar year (or part thereof) from January 1, 2015 through June 30, 2021, the cumulative weighted average TME Trend across all Payers for Partners would not exceed the cumulative TME Growth Cap (Att. A, Sec. IV(c)).

   A. The TME Trend for a Payer for a particular calendar year (each a "Measurement Period") is equal to the percent change in such Payer's total net payment per member per month for all Covered Services ("TME") from the calendar year immediately preceding the Measurement Period (each a "Baseline Period") to the Measurement Period (Att. A, Sec. IV(a)(vii)).

      (1) The TME Trend would be adjusted for the change in health status of members, the change in the proportion of member who have a pharmacy benefit through the Payers, and other benefit changes (Att. A, Sec. IV(c)(vii)).

      (2) For the South Shore entities and newly-acquired physician groups with 10 or more physicians, the Baseline Period for the first TME Trend calculation would be the calendar year prior to such provider joining the Partners Network (Att. A, Sec. IV(c)(v)).

   B. To establish a weighted average TME Trend, the TME Trend for each Payer would be weighted by each Payer's Baseline Period expenses (TME multiplied by member months) as a proportion of all Payers' TME Baseline Period expense (Att. A, Sec. IV(a)(viii)).

   C. The cumulative weighted average TME Trend would be the product of the weighted average TME Trend across all Payers in the current Measurement Period and all preceding Measurement Periods (Att. A, Sec. IV(c)(i)).

D. The TME Growth Cap would be the HPC's annually determined cost growth benchmark (3.6 percent for 2014) (Att. A, Sec. IV(b)).

E. The cumulative TME Growth Cap would be the product of the TME Growth Cap in the current Measurement Period and all preceding Measurement Periods (Att. A, Sec. IV(c)(ii)).

3. Remedy if the cumulative weighted average TME Trend is above the cumulative TME Growth Gap in a particular Measurement Period.

A. Partners would calculate an amount equal to total Measurement Period expenses (TME multiplied by member months) multiplied by the difference of the total cumulative weighted average TME Trend less total cumulative TME Growth Gap (Att. A, Sec. IV(d)(i)).

B. Partners would allocate such amount to the Payers whose cumulative weighted average TME Trend exceeded the cumulative TME Growth Gap (Att. A, Sec. IV(d)(i)).

C. Partners would provide cash settlement to Payer (Att. A, Sec. IV(d)(i)(2)).

D. Partners could request an increase to the TME Growth Cap upon a showing to the Attorney General (or the Court, if the Attorney General does not agree) that Partners exceeded the TME Growth Cap in a particular Measurement Period due to "unanticipated market conditions" that affect utilization (e.g., pandemic or government-imposed change mandating expanded benefits) (Att. A, Sec. IV(d)(ii)).

E. If the statewide average commercial TME trend for non-Partners providers in any Measurement Period exceeded the HPC cost growth benchmark by more than two percent, Partners' TME Growth Cap would be adjusted upward by the amount of the

excess (absent a compelling reason asserted by the Attorney General) (Att. A, Sec. IV(d)(i)(2)).

4. Process

   A. For each Measurement Period, Partners would provide to the Compliance Monitor: (a) the calculation of TME Trend by Payer; (b) the weighted average TME Trend across all Payers; and (c) the cumulative weighted average TME Trend (Att. A, Sec. IV(c)(iii)).

   B. Partners would provide all information or data the Compliance Monitor requests to verify whether the cumulative weighted average TME Trend exceeds the cumulative TME Growth Cap for a particular Measurement Period (Att. A, Sec. IV(c)(iv)).

      (1) If Partners believes the Compliance Monitor is requesting irrelevant information or data, it could seek relief from the Attorney General (or the Court, if the Attorney General does not agree) (Att. A, Sec. IV(c)(iv)).

C. Provider Contracting and Growth Restrictions

1. Restrictions on Affiliate Contracting

1. General rule: For 10 years from the Effective Date, Partners would: (a) cease practice of conducting Payer contracting on behalf of Partners Contracting Affiliates (Sec. 88); and (b) not renew or extend the term of any Payer Contracting provisions in agreements with any Partners Contracting Affiliate in effect on Effective Date (Sec. 81). (Please note that initially capitalized terms not otherwise defined herein have the same meaning as provided in the Proposed Consent.)

   A. A Partners Contracting Affiliate is defined as any health care provider organization that is not a Corporate Affiliate of (i.e., controlled by) Partners on whose behalf Partners negotiates rates or other terms with Payers (Sec. 47) which includes:

(1) all physicians who participate in such Contracting Affiliate for Payer contracting (including physicians leased to such Contracting Affiliate);

(2) physicians leased to a Partners-owned provider; and

(3) "managed PCHI groups" such as Charles River Medical Associates, and PCHI "affiliated groups" such as Plymouth Medical Group.

2. Payers could terminate any affected contract and negotiate a new contract (effective no earlier than January 1, 2016 for Emerson Hospital and PHO (and stayed during the regulatory review of any proposed acquisition of Emerson Hospital by Partners if the Attorney General consents (or the Court, if the Attorney General refuses to consent)), and January 1, 2015 for all other Contracting Affiliates) (Secs. 82, 83, 89, 90).

3. If Payer does nothing, the affected contract would remain in effect until earlier of: (a) three years from the Effective Date; or (b) expiration of current term (Sec. 84, 89).

4. Exception to general rule: Partners could continue to contract on behalf of Partners Contracting Affiliates that participate in Payer Contracts in connection with a Partners-owned hospital, either through the PHO of which such hospital is a member or as part of the AMC that includes such hospital (Sec. 86).

   A. This currently includes all of the Partners Contracting Affiliates that are members of and/or participate in the following Partners-owned hospital PHO or AMC: North Shore Health System, Newton-Wellesley PHO, MGH/MGPO, and BWH/BWPO.

   B. Upon closing of the South Shore and Hallmark transactions, the South Shore PHO and Hallmark Health PHO would become Partners-owned hospital PHOs, and the physicians who participate in such PHOs would be excepted from the contracting prohibition (Sec. 86).

C. If Emerson Hospital is acquired prior to the expiration of the ten-year contracting prohibition, the physicians who participate in the Emerson PHO would be excepted from the contracting prohibition (Sec. 86).

D. If Partners acquires any other hospital in Eastern Massachusetts that is a member of a PHO, upon closing of the transaction, such PHO would become a Partners-owned hospital PHO and the physicians groups that participate in such PHO for Payer contracting would be deemed to be excepted from the contracting prohibition so long as the terms and conditions of such groups' participation in the PHO are substantially the same as those applicable to participants in the North Shore Health System and Newton-Wellesley PHOs (Sec. 87).

E. After the Effective Date, any physician group (and the physicians employed by or leased to such groups) and any physicians leased to Partners-owned providers that do not contract through a Partners-owned hospital PHO or AMC could become a participant in a Partners-owned hospital PHO for Payer contracting, and thereby become excepted from the contracting prohibition, so long as such provider could demonstrate to the satisfaction of the Attorney General (or the Court, if the Attorney General does not agree) that it would have, within a reasonable period of time after joining the PHO, an integrated clinical relationship with the applicable Partners-owned hospital (Sec. 88).

(1) Relevant criteria regarding whether an integrated clinical relationship exists include: (a) membership on the medical staff of the Partners-owned hospital; (b) admitting relationship with the hospital; (c) geographic proximity of provider's practice site(s) to the hospital; (d) participation in the hospital's QI and care management programs, and in Partners' population health management programs (Sec. 86).

2. Restrictions on Partners' Physician Growth in Eastern Massachusetts

a) Community Physician Cap

1. General rule: For five years from the Effective Date, the aggregate number of Community Physicians and AMC Community Physicians in Eastern Massachusetts could not exceed the Community Physician Cap (Sec. 84).

   A. Eastern Massachusetts is defined as Essex County, Middlesex County, Suffolk County, Norfolk County, Plymouth County, Bristol County, Barnstable County, Dukes County, Nantucket County, and Worcester County (Sec. 22).

   B. For years 1-3, the Community Physician Cap is the sum of: (a) the number of Community Physicians who were participating in one or more Partners Payer Contacts as of January 1, 2012 (Sec. 95); and (b) the number of AMC Community Physicians who are participating in one or more Partners Payer Contracts as of the Effective Date (Sec. 95) (i.e., 2,770 Community Physicians in years 1-3, with approximately 55 more in each of years four and five).

      (1) As of January 1, 2012, Partners had 2,550 Community Physicians (Schedule 1).

         a. Community Physicians are defined as any physician (PCP or specialist) who is employed by, leased to, a member of, affiliated with, or participates for Payer contracting in any Partners-owned provider or Contracting Affiliate <u>other than</u> those Partners-owned providers that comprise the AMC Contracting Component (i.e., BWH, BWPO, MGH, MGPO, McLean Hospital, Spaulding Rehab. Hospital, Spaulding Hospital – Cambridge, Spaulding Nursing and Therapy Centers North End and West Roxbury, and all other facilities listed on the DPH license of any such Partners-owned provider) (Sec. 15).

i. As of January 1, 2012, Community Physicians included physicians who on such date participated in PCHI through Hallmark Health PHO (including Hallmark Health Medical Associates), but excluded physicians participating in South Shore PHO (including Physicians Organization of the South Shore and Harbor Medical Associates), who on such date did not participate in PCHI.

ii. Upon closing of the acquisition of South Shore Hospital, Harbor physicians would be deemed to be Community Physicians regardless of whether such physicians later become BWPO employees. However, Partners could seek agreement from the Attorney General (or the Court, if the Attorney General does not agree) to transfer a Harbor physician from BWPO to another Partners-owned provider (and potentially become an AMC Physician) upon a showing that it would "clinically and/or administratively burdensome and impractical" to continue to classify such physician as a Harbor physician (Sec. 33).

iii. The Attorney General stated in the press release regarding the Proposed Consent that the "acquisition of South Shore Hospital means that Partners will be within 200 [community] physicians of the 2012 [Community Physician Cap]".

iv. The HPC's final report regarding Partners' proposed acquisition of the South Shore Entities dated February 19, 2014 states that the South Shore

PHO has approximately 400 participating physicians (including the approximately 65 physicians employed by Harbor).[111]

v. Taken together, Partners would have approximately 600 open Community Physician slots on the Effective Date but prior to consummation of the South Shore transaction. This means that the Attorney General believes that Partners currently has approximately 1,950 Community Physicians.

(2) The estimated number of AMC Community Physicians as of the Effective Date is 220 (Schedule 1).

a. AMC Community Physician is defined as any physician (PCP or specialist) who: (a) is employed by, leased to, a member of, affiliated with, or participates for Payer contracting in BWH, BWPO, MGH, or MGPO; and (b) provides regular health care services to patients at a facility or office located outside of Metro Boston Core Area (i.e., Boston, Brookline, Cambridge, Chelsea, and Revere) (Secs. 2, 14, 42).

i. Community facilities are deemed to include Faulkner Hospital, and facilities or offices listed on the DPH license issued to BWH or MGH but located outside the Metro Boston Core Area (Sec. 14).

ii. This definition excludes BWPO physicians (other than Harbor physicians) practicing at Faulkner Hospital (Sec. 99).

(3) The Attorney General calculates the number of AMC Community Physicians participating in one or more Partners Payer Contracts as of the Effective Date on an

[111] *See* COMMONWEALTH OF MASSACHUSETTS, HEALTH POLICY COMMISSION, Review of Partners HealthCare System's Proposed Acquisitions of South Shore Hospital (HPC-CMIR-2013-1) and Harbor Medical Associates (HPC-CMIR-2013-2), Final Report, p. 1 (February 19, 2014).

aggregate FTE basis based on wRVUs performed by AMC physicians at community facility as compared to MGMA median wRVUs for each physician's specialty (Sec. 95).

(4) The AMC Community Physician component of the Community Physician Cap is defined based on the most recent 12 months of data available (not a historic baseline based on historic data, regarding the Community Physician component of the Community Physician Cap). As of the Effective Date of the Proposed Consent, the baseline and the cap for the AMC Community Physician component of the Community Physician Cap (approximately 220 physicians) would be identical. The cap for the AMC Community Physician component would remain the same during the five-year period of restricted Community Physician growth.

C. For years 1-3, the Baseline Community Physician Cap is estimated to be 2,770 Community Physicians (Schedule 1).

D. For years four and five, the Community Physician Cap would be equal to 102 percent and 104 percent of the Baseline Community Physician Cap (2,770), respectively (Secs. 96, 97).

(1) This means that Partners could add approximately 55 additional Community Physicians (including AMC Community Physicians) in each of year four and five.

b) AMC PCP Cap

1. General rule: For five years from the Effective Date, the number of AMC PCPs could not exceed the AMC PCP Cap (Sec. 100).

A. For year 1, the AMC PCP Cap would be 10 more AMC PCPs than the number of AMC PCPs as of the Effective Date (Sec. 101).

(1) The estimated number of AMC PCPs as of the Effective Date is 169 (Schedule 1).

(2) AMC PCPs are defined as any physician who: (a) is employed by, leased to, a member of, affiliated with, or participates for Payer contracting in BWH, BWPO, MGH, or MGPO; (b) is a primary care, family practice, or pediatric physician that is identified as a PCP by any of BCBS, HPHC, or Tufts; (c) has a principal office located within the Metro Boston Core Area (i.e., Boston, Brookline, Cambridge, Chelsea, and Revere); and (d) has the following aggregate panel size enrolled in BCBS, HPHC and Tufts: (i) more than 300 for pediatric physicians; (ii) more than 300 for primary care or family practice physicians who practice at a BWH or MGH-licensed community health center; and (iii) more than 200 for all other primary care or family practice physicians (Sec. 4).

(3) Attorney General calculates number of AMC PCPs each year based on the most recently available panel size data (Sec. 4).

B. For each of years 2-5, the AMC PCP Cap would increase by another 10 AMC PCPs, and Partners could seek agreement from the Attorney General (or the Court, if the Attorney General does not agree) to increase the AMC PCP Cap by 20 AMC PCPs in each year upon a showing that the additional AMC PCPs: (a) are new to the market (i.e., from outside of the Metro Boston Core Area or recent graduates); (b) are needed to serve at-risk, underserved, or government payer populations; (c) would not materially increase costs; and (d) would not materially decrease competition among affected providers (Sec. 103).

c) Other Restrictions and Terms Relating to Physician Growth

1. For five years from the Effective Date, Partners must provide the Attorney General with 30 days prior notice of any proposed transaction by any Partners Corporate Affiliate that involves the acquisition of, employment of, or affiliation with (including a leased physician arrangement): (a) any physician group of 11 or more physicians whose principal office is located in Eastern Massachusetts; or (b) any physician group of four or more physicians whose principal office is located in Cambridge, Chelsea, Everett, Malden, Somerville, or Revere (Sec. 104).
2. For a period of five years from the Effective Date, Partners could not solicit existing practice groups (including primary, secondary, and tertiary AMC physicians) at competitor AMCs in Eastern Massachusetts to join Partners as employees, as Partners Contracting Affiliates, or otherwise. However, Partners is free to respond to "unsolicited overtures" from existing practice groups, and to recruit from non-AMC competitors inside of Eastern Massachusetts and from any competitor outside of Eastern Massachusetts (Sec. 105).

3. Restrictions on Partners' Hospital Growth in Eastern Massachusetts

1. For seven years from the Effective Date, Partners could not acquire any Hospital in Eastern Massachusetts (except for Emerson Hospital) without prior review and approval by the Attorney General, which could be granted or denied in the Attorney General's discretion (Sec. 91).
   A. Hospital is defined as any hospital licensed under MGL ch. 111, §51, the teaching hospital of the UMass Medical School, and any psychiatric facility licensed under MGL ch. 19, §19 (Sec. 38).

B. This discretionary review would not apply to Emerson Hospital. However, any proposed acquisition of Emerson Hospital would be subject to review under applicable law.

D. Monitoring/Funding

1. The Attorney General would retain a Compliance Monitor to assist the Attorney General in monitoring Partners' compliance with the terms of the Proposed Consent by conducting an ongoing review of Partners' practices that are affected by the Proposed Consent (Sec. 112).
2. The Attorney General would consult with Partners in retaining the Compliance Monitor (Sec. 112).
3. The Compliance Monitor would have the authority to: (a) require Partners to provide any non-privileged documents, records, data, or other information relevant to any of Partners' obligations under the Proposed Consent (whether or not in the possession or control of Partners); and (b) upon reasonable notice, interview directors, officers, managers, employees, or independent auditors of Partners, as relevant to any of Partners' obligations (Sec. 1124.
4. Partners would waive any confidentiality obligation third parties may have to Partners regarding information in the possession or control of such third parties, to the extent necessary for the Compliance Monitor to perform its duties (Sec. 115).
5. For each year of the 10-year term of the Proposed Consent, the Compliance Monitor would be required to issue an annual report to the Attorney General (and such interim reports requested by the Attorney General, or upon the Compliance Monitor's initiative) regarding Partners' compliance with the terms of the Proposed Consent (Sec. 118).
   A. The reports would be made available to the public when final (excluding information reasonably asserted by Partners to be confidential commercial or trade secret information) (Sec. 120).

6. The Compliance Monitor and any individuals or firms hired to assist the Compliance Monitor would be required to execute a confidentiality agreement with the Attorney General and Partners (Sec. 121).
7. The Compliance Monitor and any individuals or firms hired to assist the Compliance Monitor would be compensated consistent with a scope or work and budget from an account funded exclusively by Partners (Sec. 126).
   A. Partners would make an initial deposit of $2 Million into such account, and deposit an additional $250,000 whenever the balance of the account falls below $100,000 (Secs. 127, 129).
   B. Partners would seek agreement with the Attorney General (or the Court, if Partners and the Attorney General cannot reach agreement) on the Compliance Monitor's annual budget (Sec. 128).
   C. If the Attorney General determines it is necessary to make distributions to the Compliance Monitor exceeding the applicable annual budget, it could seek agreement with Partners (or the Court, if Partners does not agree) (Sec. 112).

EXHIBIT A

EXAMPLE OF UNIT PRICE GROWTH GAP PRODUCING ACTUAL PRICE INCREASE GREATER THAN INFLATION

	A	B	C = A * B	D = C (*service*) / C (*total*)	E	F = A * (E+1)	G	H = B * F	I = G * F	J = I (*service*) / I (*total*)	K = ($E_{Inpatient}$ * $F_{Inpatient}$) + ($E_{Outpatient}$ * $F_{Outpatient}$)	L = ($E_{Inpatient}$ * $K_{Inpatient}$) + ($E_{Outpatient}$ * $K_{Outpatient}$)
	BASELINE PERIOD				MEASUREMENT PERIOD						PRICE INCREASE	
Service	Unit Price	Volume	Actual Payments	Actual Payments for Each Service as a Proportion of Total Actual Payments	Unit Price Increase	Unit Price	Volume	Theoretical Payments	Actual Payments	Actual Payments for Each Service as a Proportion of Total Actual Payments	Price Increase under Proposed Consent (RPI): Total price increase, weighted by Baseline Period Payments	Actual Price Increase: Total price increase, weighted by Actual Measurement Period Payments
Inpatient	1	8	8	80%	1.0%	1.01	4	8.08	4.04	39%		
Outpatient	1	2	2	20%	6.0%	1.06	6	2.12	6.36	61%		
Total		10	10	100%			10	10.2	10.4	100%	2.0%	4.1%